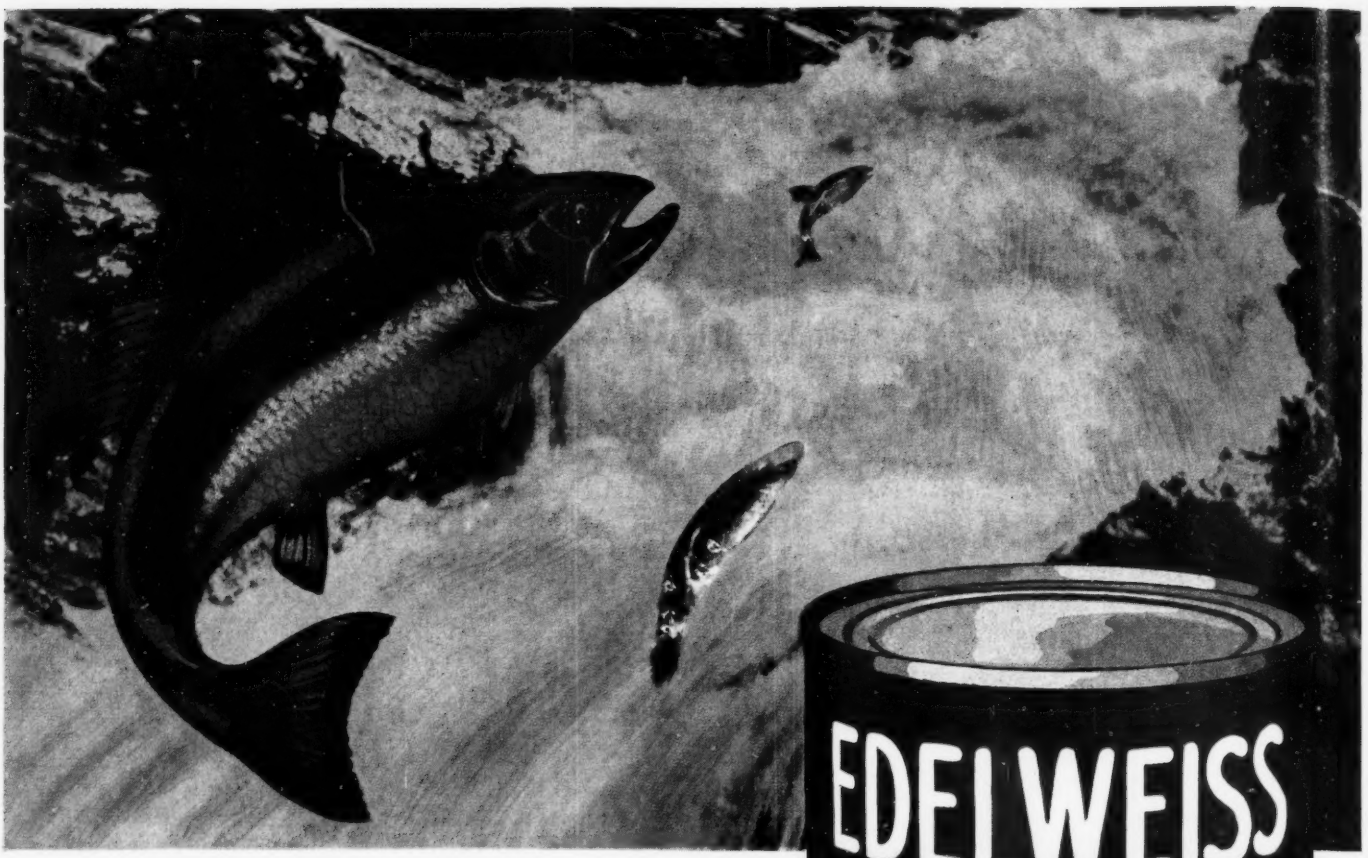
The MODERN HOSPITAL

Volume 44 FEBRUARY, 1935 No. 2



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For February, 1935

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Just in Passing—

ALL eyes center on Washington these days. The hospital field is particularly concerned with the recommendations of President Roosevelt's committee on economic security. Part of this committee's work has been completed and presented to Congress. But the part that most concerns hospitals, namely, the recommendations regarding health insurance, have not yet been formulated. The medical, dental and hospital advisory committees are in session in Washington as this goes to press. Their reports are due about March 1. The distinguished personnel of these advisory committees assures a careful and sympathetic consideration of their proposals by the hospital field.

IT IS the duty of a president to lead in thinking out the problems of his constituents. This Doctor Buerki is doing for the hospital field. His ground-breaking article appears on page 37.

WHILE the Middle West is now shivering with below zero weather and other parts of the country are enjoying an unusual cold spell, it may seem unseasonable to present an article on hospital gardens. Actually it is most timely. Gardens must be planned and now is the time to do it. The article on the gardens at Muhlenberg Hospital should help you in planning (page 40).

DOCTOR Nissen challenges us all to take a look at a more or less neglected field of hospital work. He shows how we may cultivate it effectively (page 45).

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OUT of the ashes Robert Packer Hospital has arisen more beautiful than before. The description of it on page 47 shows how the newer aspects of hospital planning have been embodied in one of the most recent hospitals.

HOSPITAL personality is essential. But how may it be achieved? It has been achieved to an unusual degree by the Children's Memorial Hospital of Chicago, not by vaguely hoping for it but by carefully analyzing the factors necessary to build a hospital personality (page 54). What this hospital has done others in their respective fields can also do — whether they be large or small, general or special. The important thing is to treat hospital patients with the same genuine consideration that one would treat members of one's own family.

LET'S take a look at the housekeeper. She fills a very important niche in hospital organization. With careful organization of her work, analysis of the work of those in her department and selection of competent help she can make her department a smooth-running cog in the hospital machine (page 73).

THE architecture of small hospitals is a much neglected field. Next month, as is pointed out in our editorial columns, the small hospital is to receive special attention in the columns of The MODERN HOSPITAL. As this issue has taken definite shape over the last few months, we must confess to a mounting enthusiasm for it. While it is designed especially for the hospital of less than fifty beds there will be much material of interest to the administrators of larger hospitals. The portfolio of floor plans of small hospitals will be especially valuable. Architects and superintendents have cooperated generously to make this outstanding.

ANOTHER article of unusual importance in the March issue will start a discussion of plumbing hazards in hospitals. Dr. Herman

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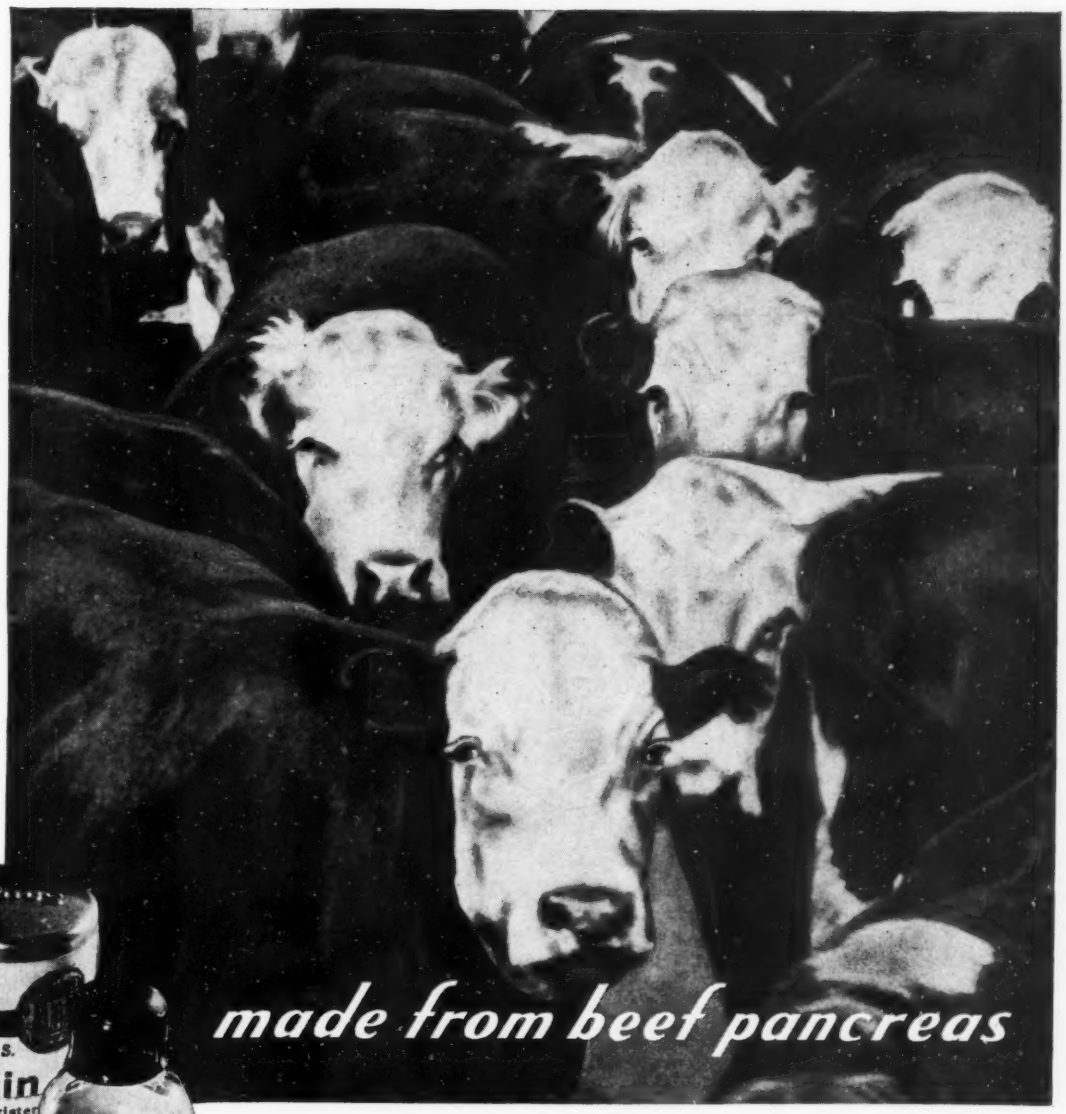

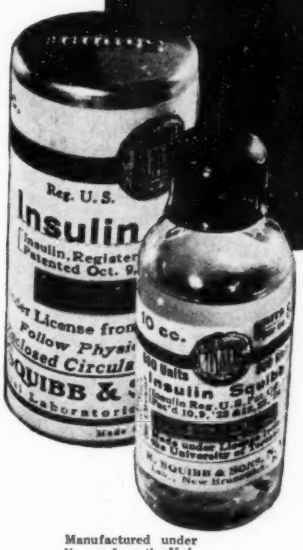

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FLASHES FROM THIS ISSUE:

"Hundreds of thousands of people need hospital service which they are not obtaining, yet in the face of that hundreds of millions of capital invested is wasted by idle hospital rooms." *Page 39.*

"The dietary department which spends so large a portion of the hospital dollar must find a way to reduce expenditure." *Page 96.*

"A coordinated plan to provide both medical and hospital service on a periodic payment basis, controlled by the profession and the hospitals and with the proper safeguards, may avert the crippling of medical practice and the ruin of the voluntary hospital system." *Page 60.*

"Beginning with the last week in June, each year, no vegetables are purchased during the summer months other than potatoes, lettuce and celery, and the hospital feeds approximately 450 people three times a day." *Page 41.*

"The life of cleaning equipment depends to a great extent on whether it is given proper care when it is not in use." *Page 75.*

"Few will challenge the statement that at least one out of five of the charts as they reach the record librarian requires correction, addition or alteration." *Page 69.*

"Unless we can impress upon every employee the fact that the only reason for the existence of the hospital is the patient, our institution will never reach the standard it should." *Page 57.*

"No institution can claim to be properly equipped unless it has some modern type of oxygen apparatus at hand." *Page 83.*

THE MODERN HOSPITAL

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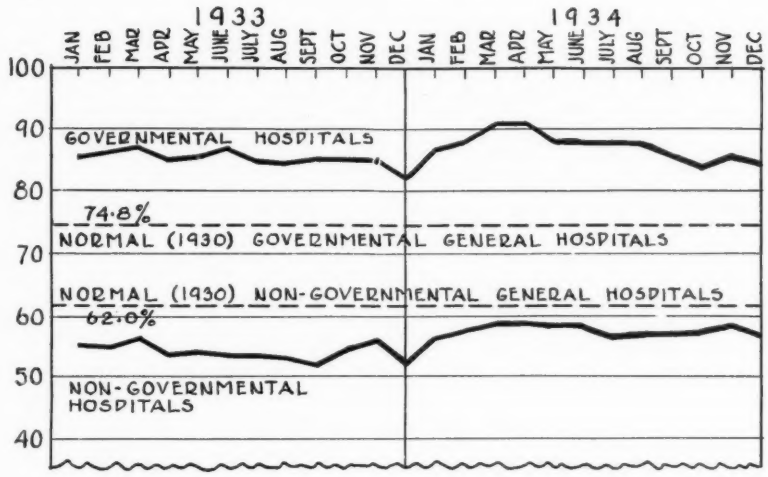


The nongovernmental hospitals which are cooperating in the presentation of occupancy figures on this page closed the year with a much higher occupancy than they had last year. There was a slight seasonal decline in December but it was much less than in 1933. The occupancy for the entire year 1934 in the nongovernmental hospitals was 57.9 as compared with 54.3 in 1933. Occupancy in the cooperating governmental hospitals declined slightly more in December than in the nongovernmental institutions. The yearly average for the governmental group also increased from 85.5 in 1933 to 87.6 in 1934. Since April, however, occupancy in governmental hospitals has declined substantially although December, 1934, was higher than the same month of the previous year.

New hospital building projects were practically at a standstill over the holidays. Only six additions to hospitals were reported.

General business conditions were good at the turn of the year according to the U. S. Department of Commerce survey of current business. Industrial production has continued to expand, with the steel and automobile industries showing further gains in output and the textile industry resuming operations on a broader scale following the year-end curtailment for inventory. Gains were also recorded for electric power output, freight car loadings and bank debits outside of New York City. The lumber and construction industries continued to lag.

The sharp advance in industrial production was counter to the usual movement for December according to the National Industrial Conference Board.

Wholesale prices rose from an index of 76.3 on December 22 to 79.3 on January 19, according to the *New York Journal of Commerce*. Grain prices rose somewhat and fell again during this period but continued at their generally high level. Food on the other hand rose rapidly in price, the index going from 67.8 on December 22 to 77.8 on January 19. Textiles, fuel and building materials remained at approximately the same levels as in the pervious month. The price index for drugs and fine chemicals of the *Oil, Paint and Drug Reporter* remained unchanged.

The cost of living for industrial wage earners as computed by the National Industrial Conference Board averaged exactly the same in December as in November, declines and advances offsetting each other. The figures for January, when they become available, will probably reflect in some measure the marked change in food prices.

Occupancy Figures of Hospitals in Various States and Cities

Type and Place	Census Data on Reporting Hospitals[1]		1933	1934											
	Hospitals	Beds[2]	Dec.	Jan.	Feb.	Mar.	April	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.
Nongovernmental															
New York City[3]	68	15,194	65.0	69.0	70.0	73.0	75.0	75.0	75.0*	66.0	62.0	61.0	66.0	68.0	68.0*
New Jersey	58	9,772	57.0	58.0	62.0	63.0	63.0	63.0	61.0	61.0	59.0	58.0	60.0	61.0	61.0*
Washington, D. C.	9	1,763	57.7	61.7	65.0	67.2	65.8	62.8	62.8	58.4	59.3	60.7	65.4	65.3	61.8
N. & S. Carolina	97	5,717	51.3	54.0	57.3	59.2	59.4	59.6	62.1	62.6	62.3	60 9	61.1	60.9	56.8
New Orleans	7	1,196	43.1	42.4	43.4	46.5	42.1	43.2	48.4	43.3	52.1	49.5	49.5	47.7	44.9
San Francisco	15	2,825	53.9	59.5	63.0	61.9	61.6	60.3	58.1	56.8	56.9	60.8	64.2	63.2	62.0
St. Paul	6	912	46.0	51.8	53.8	49.4	50.7	47.3	49.1	44.9	45.7	43.4	39.1	45.8	45.8
Chicago	23	6,003	49.1	53.1	53.5	53.3	55.4	56.5	57.7	57.3	59.3	55.6	56.9	57.9	54.5
Cleveland	12	2,838	55.0	57.0	58.0	58.0	61.8	59.9	61.3	60.0	58.4	56.7	57.8	57.7	57.4
Total[5]	295	46,220	52.6	56.3	58.4	59.1	59.4	58.6	59.5*	56.8	57.2	56.3	57.7	58.6	56.9*
Governmental															
New York City	16	11,615	104.5	100.7	100.0	105.0	103.7	101.9	93.7	91.3	89.5	88.3	89.4	91.0	92.9
New Jersey	6	2,122	82.0	89.0	94.0	93.0	91.0	90.0	86.0	85.0	80.0	80.0	83.0	81.0	81.0*
Washington, D. C.	2	1,076	87.8	87.1	88.3	83.2	84.3	84.7	84.7	79.0	80.2	81.7	78.1	84.8	77.6
N. & S. Carolina	13	1,136	50.6	58.6	65.8	66.4	66.8	64.5	69.4	70.6	66.9	64.0	67.0	68.3	64.7
New Orleans	2	2,227	96.8	106.6	112.5	129.5	136.4	127.1	137.9	148.7	152.4	148.0	129.3	131.6	124.9
San Francisco	3	2,315			77.4	79.2	76.7	80.7	77.7	76.4	77.9	74.4	72.7	78.1	74.2
St. Paul	1	1,050	72.4	79.8	78.5	76.9	76.3	76.1	73.2	69.0	68.0	67.3	66.8	68.5	68.8
Chicago	1	3,101	80.6	92.8	94.3	93.2	94.6	91.1	87.5	84.8	83.7	83.1	84.8	87.0	84.7
Total[4]	44	24,642	82.1	87.8	88.8	90.8	91.2	89.5	88.8	88.1	87.3	85.9	83.9	86.3	83.6*

[1]Insofar as possible hospitals for tuberculous and mental patients are excluded as well as hospital departments of jails and other institutions. The census data are for the most recent month. [2]Including bassinets, in most instances. [3]Includes only general hospitals. [4]The occupancy totals are unweighted averages. These averages are used in the chart above. *Preliminary report.

THE MODERN HOSPITAL

A Monthly Journal Devoted to the Construction, Equipment, Administration and Maintenance of Hospitals and Sanatoriums

VOLUME 44 *February, 1935* NUMBER 2

Do Your Capital Dollars Earn Full Service Dividends?

By R. C. BUERKI, M.D.
Superintendent, State of Wisconsin General Hospital, Madison

THE need for hospitals and similar public health institutions may be basic and the advance of medical science and the esteem for medical men may be a condition indispensable to a high civilization. Yet it does not follow that our defense of the public's health or our attack upon disease, as now directed, utilizes to best advantage the means we have at our disposal.

By force of circumstances, we started to organize our practices without plans. "Lean-to" would describe much of our building. There has been, and is now, very little organization (in the Baconian sense) in medical science.

Our whole system of combating disease is traditional in character. We move slowly and sometimes irrationally in a system which has directly to do with life and person, the sanctities of which are recognized in all progressive societies.

Certain aspects of medical practice, such as the contact of the professional man with his individual patient, are not easily measured by the purely metrical methods of science. We like to say that they partake of an art, the art of healing, and I hope we shall never forsake that art.

There are, however, other aspects of our defense of health which I think can and should be submitted to most rigorous scientific investigation and analysis. Hospital management is one of these.

Too much capital investment for the treatment of acute disease and not enough for subacute. Too much for surgery; not enough for medicine. Too much investment in plant and equipment that is idle a large share of the time. These are Doctor Buerki's charges. His remedies will challenge your thinking. They are worth considering by large and small hospitals

Nearly everywhere in the field of social action results may be measured by the engineer's formula which says that progress simply depends upon the organization of men and materials. The better we organize our men and materials, both with relation to a problem and to each other, the more effective we become. The proper relation of personnel to material facilities and of both to the task will assure

the greatest efficiency and economy and guarantee the largest end results. Conversely, if these factors are not properly related we may expect waste of materials, futility of action, duplication of effort, and a degree of failure.

Furthermore, in a capitalistic economy, capital dollars and materials are interchangeable quantities and have very definite and tangible values in the current operation of any organization.

Now if we apply this formula to our organized defense of public health and our attack upon disease, how will it assist us in an analysis of our present situation and the prediction of our future?

To begin with, we must consider our three and a half billion dollars capital investment in American hospitals. As a matter of practical fact, the public's investment in health is largely represented by hospitals and our hospitals were built almost wholly by funds from the public. Are we employing that capital to the best advantage?

Unsuspected Sickness Is Costly

If we consider the problem of disease broadly we must first look at it in its two principal forms, namely, acute disease and subacute disease, and if we measure sickness by the degree to which disease destroys the general effectiveness and well-being of the individual, we encounter some astonishing facts.

We think of an acute sickness lasting perhaps a month as being very expensive of the patient's well-being, effectiveness and money. But it is probably a fact that over a period of ten years the sicknesses which cost the individual most in lost earnings, shortened life and general unfitness to cope with environment, are sicknesses which are rarely specifically observed or treated and of which the individual is frequently ignorant.

It is probable that low grade infections, fevers, and physical maladjustments are actually responsible for more deaths than are acute diseases. True, the patient's death certificate recites that he died of pneumonia or tuberculosis or some other acute disease. But in a broad view, these are just incidental attacks which find their victims weakened by other, and in many cases undiagnosed, diseases.

For instance, in passing through the present economic depression statements are made from time to time which imply that America is healthier than during more prosperous years. From the low death rates it is inferred by some public health officers that the incidence of disease now is less than it was during a few preceding years of plenty. Medical men know that these statements must be viewed with skepticism; that in fact they may give a false sense of security to the public. Probably less sickness is being observed specifically, and persons who used to see their physicians regularly are not doing so now.

In any event, in a general view of what we now know it seems quite likely that the biggest health problem of society since the elimination of plagues is to be found today in the subacute undiagnosed and unknown disease of the man who walks the street, does his work and is largely ignorant of his sickness.

Now if this is so, what is the future of the general hospital with relation to this problem? How can this problem get its fair share of support from the three and a half billion dollar structure we have built to fight disease in America? The answer seems plain enough. Hospitals must turn more of their capital support and material facilities over to the more extensive organization of departments treating and giving service to nonresident or ambulatory patients. Thus they would organize their total service to the whole community on a much broader base which would feature more direct and closer contact with a larger number of persons.

We need not at this time specify the type of organization which might best serve the purposes of such a department or departments. That can only be determined practically by experimentation. Certain it is, however, that here is a fundamental need and that in organizing to fulfill it, we would work our capital dollars to the broader advantage of the whole community. It is pertinent to note that experience to date would indicate that, volume for volume, work thus done would require less capital than most other existing or potential hospital services. Conversely, it would make the same capital more productive. And, of course, it would require and use more professional man power.

This problem of distribution of capital facilities is our biggest management task. In trying to give proper weight to each of these aspects of sickness, it becomes clearer that the big job confronting hospital administration is that of spreading capital facilities to meet the wider needs of the public. Through no fault of any group but rather because of what we did not know, capital has been massed behind the treatment of a fractional aspect of disease.

Let Us Consider Acute Disease

Let us look further. Let us turn our attention specifically to acute disease. Fifty years ago few people in this country could be induced to enter a hospital unless they were indigent and could not afford home nursing service or were in critical need of surgical treatment. Our hospitals have grown miraculously during that time but the pub-

lic's comprehension of what the hospitals can more economically and effectively do today to combat disease has not kept pace with the actual potentialities. In the beginning they served the surgeon and the surgical case almost exclusively, and to this day, American hospitals exist preponderantly for that purpose.

Yet acute surgical cases represent only a small fraction of our total sickness which should be combated with every bit of medical organization we have at our disposal, including the hospital.

We can, I believe, predict with confidence that the day is near when it shall be demonstrated beyond doubt that a far wider variety and greater percentage of acute cases should be hospitalized in the interests of more effective and cheaper treatment for the patient.

In short, the more we understand the nature of disease, the harder it is to believe that the hospital is more appropriate for the surgical case than it is for the acute medical case — that the surgeon or the surgical case should take precedence of the physician and his nonsurgical case.

And, we should, I think, urge this with every means we have for educating the public, no less because it is a matter of sound economics for the hospital and patient than because we are enlisted in the cause of public health and devoted to it.

Duplication Responsible for Waste

So much for what we might call misapplied or distorted use of capital. How about capital duplications? The most outstanding example, and the one which is most expensive to the profession, the hospital and the patient, is duplication of the hospital's machines by physicians who are not members of the staff or who, if they are, find it inconvenient to use hospital equipment.

A good instance of this is to be found in x-ray equipment—equipment which is necessarily expensive. It is not uncommon to find many thousands of dollars worth of apparatus of this nature in a good hospital, used only to a small percentage of its capacity, and yet find even the physicians and surgeons connected with the hospital duplicating this investment in half a dozen different offices in the community.

From an economic point of view this is outright duplication of capital and patients or practitioners have to pay for it. That is part of the reason why some who are sick cannot afford the treatment and attention they should have. Either the patient pays for the waste, or, not having charged the patient, the professional man and the hospital find themselves poorer at the end of the year.

It seems to me fair to conclude that much of such capital duplication could be eliminated in the future by permitting many of the hospital's service departments to be so organized that it would be convenient for community physicians and surgeons to obtain the services of these departments or units at reasonable cost by appointment.

Finally, what part of our capital and material facilities are being completely wasted? The vacant hospital room is the best example of this, and the general hospital occupancy figure for the last five years brings this forcibly to our attention.

Hundreds of thousands of people need hospital service which they are not obtaining, yet in the face of that hundreds of millions of capital invested is wasted by idle hospital rooms. And the cruel irony of the situation is that many people who provided money to help build these rooms are people who now need them and cannot afford them.

Idle Dollars Needed for Service Program

There are some who profess not to see any great waste in the idleness of this invested capital because, they point out, most of the money invested in hospital plants in America was money donated by individuals out of surplus. This view completely ignores the fact that in a capitalistic economy, capital dollars must work or they are a sheer waste. It overlooks another fact, namely, that capital dollars tied up in idleness are held out of productive enterprise. Last, and most important from the humanitarian point of view, these idle dollars were meant to relieve human suffering. They do not do it. If in the field of hospital management we can devise no means of relieving this situation we are justified, even morally bound to use what idle capital dollars we can in service programs.

In conclusion, we are, I believe, justified in saying that we have a large waste of capital resources in our attack upon disease; we have, in marked instances, a great deal of duplication of capital goods, and we have a disproportionate amount of capital massed behind the treatment of fractional aspects of disease.

Because of this we are also wasting the man power of the personnel of medical science at considerable cost to the profession and to the sick.

This situation has been built up almost vertically until in the present economic stress when health and morale are low, when every capital dollar should be working to its absolute capacity to keep health up to a high level and cost down, we witness great idleness of capital invested in hospitals.

We know that generally speaking there is but one solution for this situation. We must deploy our forces and facilities over a wider area. We must spread our resources horizontally so that the base of our hospital structure can be made more secure through broader service to the community.

When the Hospital Goes

By RAYMOND P. SLOAN
Associate Editor, The MODERN HOSPITAL

"YOU can tell it by the gardens around it." A bit perplexed, the stranger proceeds on his way, trusting that his guide heard correctly — that it is a hospital he is seeking — Muhlenberg Hospital in Plainfield, New Jersey. Then comes the following reassurance, "You can't miss it. It has lots of trees in front of it, many flower beds and a large vegetable garden."

Muhlenberg Hospital is known, in other words, by the gardens it keeps. Their fame has long since spread beyond local boundaries and become a subject for comment far and wide. Each spring twenty thousand tulips form huge blankets of bounteous bloom spread here and there on green lawns and along paths which lead from one building to another. In summer, touched as by some magic wand, gay zinnias, petunias, phlox and other hardy garden flowers form quaint patchwork quilts here and there. Fall finds these same garden spots assuming shades of deep yellow and gold while tawny chrysanthemums stand stiffly against the protecting warmth of the buildings, each shrouded in white as a protection against early frost. Cold weather, too, plays all manner of sleight-of-hand tricks, glazing the feathery branches of trees and bushes with coatings of snow and ice which sparkle brilliantly in the winter sun.

Such effects are not achieved without careful planning and consistent effort. Frequently they represent the interest or hobby of some individual. At Muhlenberg it is Marie Louis, who in addition to acting as superintendent of a hospital of 240-bed capacity, finds time to serve as keeper of its gardens. Under her close supervision new features are developed. Gardens are rearranged. Many types of flowers and vegetables are grown, and numerous interesting experiments made which are always so essential to successful gardening.

Aside from the personal satisfaction she derives from making the gardens of her hospital a place of beauty for the entire neighborhood and in which it may take a justifiable pride, Miss Louis after many years of gardening is willing to vouch for the fact that it pays. Her flower gardens, she has found, have returned substantial dividends in the good will they create for the hospital. A vegetable garden, she believes, is economical when properly managed in that it can supply the institution with fresh vegetables which otherwise would be impossible and also provide for the winter months when food costs rise.

Much depends, obviously, upon the climate, the

Each season brings its own individual charm to the grounds of Muhlenberg. Small wonder that the hospital is known by the garden it keeps. Opposite is shown a view of the beautiful rock garden, once an old sewage bed. This transformation was made possible by two cartloads of rocks and the effective planting of perennial shrubs banked with the tall stately spikes of lupine, foxglove and delphinium. On the right appears the main entrance to the administration building.

in for Gardening

—as exemplified at Muhlenberg Hospital

amount of property the hospital has at its disposal, the type of soil with which it has to work, and countless other factors. Given favorable conditions, however, it is evident that a truck garden can be operated profitably and that effective landscaping is an important factor in establishing community relations.

Muhlenberg Hospital has twelve acres of its own. In addition, six adjoining acres are leased for garden purposes. Beginning with the last week in June, each year, no vegetables are purchased during the summer months other than potatoes, lettuce and celery, and the hospital feeds approximately 450 people three times a day. The dietitian can go to the garden at any time and select from eighteen to twenty different kinds of vegetables. Each fall, too, finds the shelves in the stockroom well filled with canned goods for use during the months when green things are scarce and costs run high. One day last autumn, for example, 244 quarts of grape jam were prepared. During the season, 1,200 quarts of peaches and tomatoes were also canned. Two trees on the hospital grounds furnished twenty bushels of pears, and the yield of carrots has reached as high as six bushels a day.

It has already been emphasized that results are dependent upon such factors as the type and extent of the property and the quality of the soil. Another exceedingly important consideration is the gardener in charge. Much depends upon his knowledge, his willingness to cooperate, his ability to get work done himself as well as to get the maximum return from those working under him, and his interest in experimenting and planning.

It has been found at Muhlenberg that a head gardener and two or three assistants employed as the season warrants are sufficient to carry on the work. During the winter months when outside activity centers principally in the greenhouse, the staff is cut to a minimum.

In contemplating even the most modest excursion into gardening, careful planning is requisite to success. One of the features which impresses the visitor to Muhlenberg is the effective use of beds and borders. These obviously must be so arranged as to provide bloom through the greater part of the season.

Each May a grand array of tulips and spring flowers is on exhibition attracting the attention of all visitors to the hospital as well as the thousands who pass and make a point of seeing the Muhlenberg gardens in spring attire. These bulbs are set out in the fall after the last of the summer flowers have disappeared. With the approach of cold weather, the ground is mulched with leaves, salt

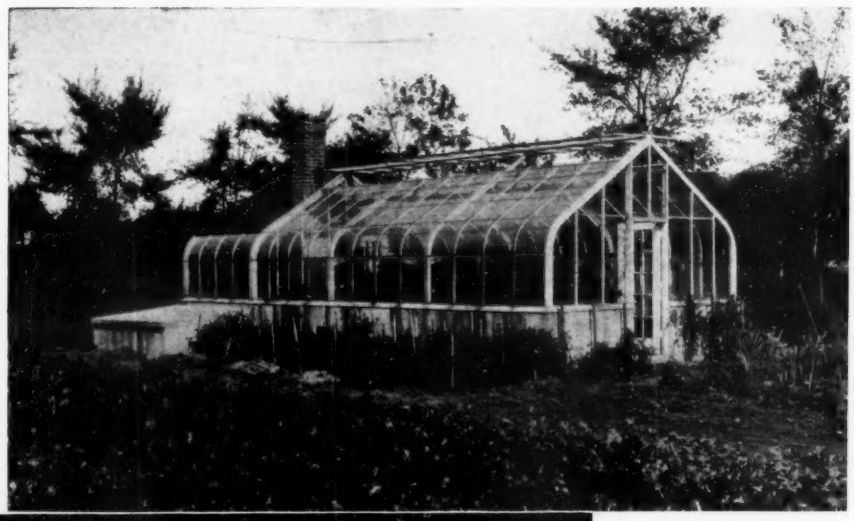
hay, pine branches or some similar covering and the bulbs given a chance to prepare for their blooming season.

As the rays of the sun assume spring warmth, this protective covering is removed, fertilizer scattered over the beds, and soon the leaves show above ground and buds start to form. After the blossoming season has passed, these bulbs are dug up and given a chance to rest during the summer while the beds are prepared for summer and fall plantings. Borders of sweet alyssum or possibly begonias then frame colorful patches of zinnias, marigolds and asters.

What makes every landscaping plan interesting are the little features which are encountered quite unexpectedly. These may take such forms as rock gardens, pools or a sunken winter garden comprising various species of pines, hemlocks and other evergreen plants. Frequently, too, such details may be evolved from a spot hitherto an eyesore.

It is difficult, for example, to visualize the artistically developed rock garden at Muhlenberg as an old sewage bed. Yet that is precisely what it was before two cartloads of rocks were used as the basis of its transformation. Stepping stones set in the grass lead to this bit of green lawn about which perennial shrubs and plants have been banked, with the tall, stately spikes of lupine, foxglove and delphinium forming a colorful background for the clusters of mosses and dainty flowering plants always present in rock garden collections. The effect is completed by sun dials which were presented to Miss Louis in recognition of her interest in landscaping the hospital grounds.

Much of the expense involved in effecting such little details has been borne by members of the board and friends who have wanted to participate in beautifying the property. Such contributions as packages of seed from England or money with which to buy some new tulip bulbs are not uncommon. Bird baths placed here and there likewise attest to this interest and have been instrumental in developing within the hospital grounds a veritable bird sanctuary. Goldfinches, blue jays and other feathered members of the summer colony may be seen daily splashing about happily. It is surprising how much a small pool will add



A greenhouse on the property ensures potted plants for the hospital throughout the winter.

No vegetables are purchased during the summer months other than potatoes, lettuce and celery and the hospital feeds approximately 450 people.

A small pool brings added beauty to the surroundings at comparatively low cost. Tables with umbrella tops under the big trees surrounding it contribute to the color of the scene and a bird bath completes the ensemble.

to the beauty of the surroundings. A particularly advantageous spot was discovered just to one side of the rock garden on the Muhlenberg grounds. Here, encircled with pines, rhododendrons and laurel, a circular pool was installed with a fountain in the center. Its exterior rim is softened by bright colored flowers. Tables with umbrella tops and chairs placed on the grass under the big trees adjoining it contribute to the color of the scene. The fountain cost but $198 and was the gift of an interested friend.

Hospital windows reveal beautiful vistas whatever the time of year, bringing new cheer to visitors and patients alike. When outdoors beckons and makes more difficult the long days spent within hospital walls, wheel chairs are rolled into the rock garden or under the shade of one of the huge trees not far from the pool. Rest and relaxation are likewise afforded nurses and other employees who enjoy leisure hours spent in the open.

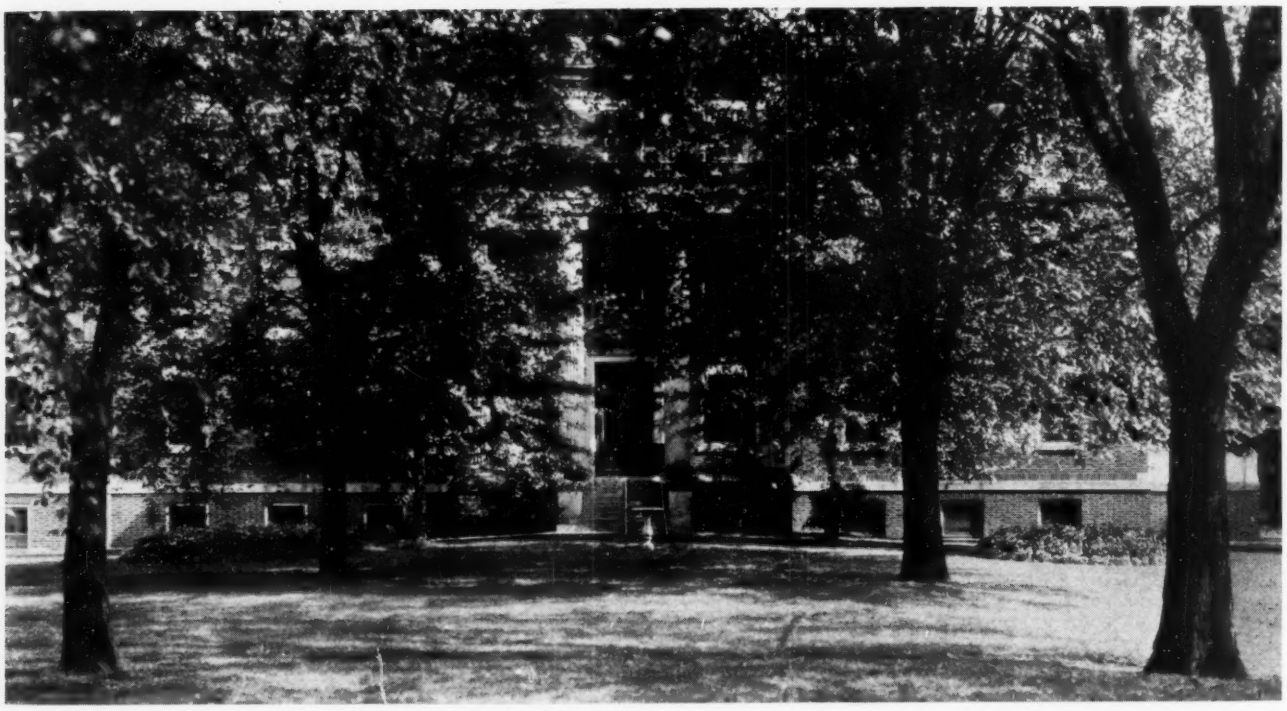
A greenhouse is not the extravagance that many believe it to be. In fact, it plays an almost essential part in any well conceived gardening scheme. It does not have to be large. Its primary services are those of storing ferns and potted plants taken from the hospital to enjoy a process of renovation which they all need, also to develop plants from seeds or cuttings which will later be used in outdoor work. This refers to begonias, chrysanthemums, asters and similar plants. And there is no end to the wonders it will produce if presided over by a gardener possessing ingenuity!

The presence of a greenhouse on the property ensures potted plants for the hospital throughout the winter. Without too great effort, lilies may be raised in time for Easter and appropriate flowers for the Christmas season, such as poinsettias. Late flowering chrysanthemums, particularly the small button varieties, are sufficiently hardy to ensure flowering right through November into December. A particularly interesting type which falls into a great cascade of brilliant bloom is Miss Louis' latest achievement.

Even if a greenhouse is outside the realm of possibility, there is little excuse for doing without a coldframe. This is easily constructed and will provide a head start when it comes time to prepare for the summer planting after the spring flowering bulbs have died away. Unfortunately, it cannot start to function until well into the spring.

The same careful planning that is so necessary in every phase of gardening becomes even more essential perhaps in laying out the vegetable garden. Not only must extreme care be exercised in selecting types of seed but a schedule must be arranged whereby a sufficient volume of product is assured to meet the needs of the institution.

Some latitude is provided, of course, in the use to which vegetables are put in the kitchen. For example, beets that get too big may easily be



Despite the time of year hospital windows reveal beautiful vistas bringing new cheer to visitors and patients alike.

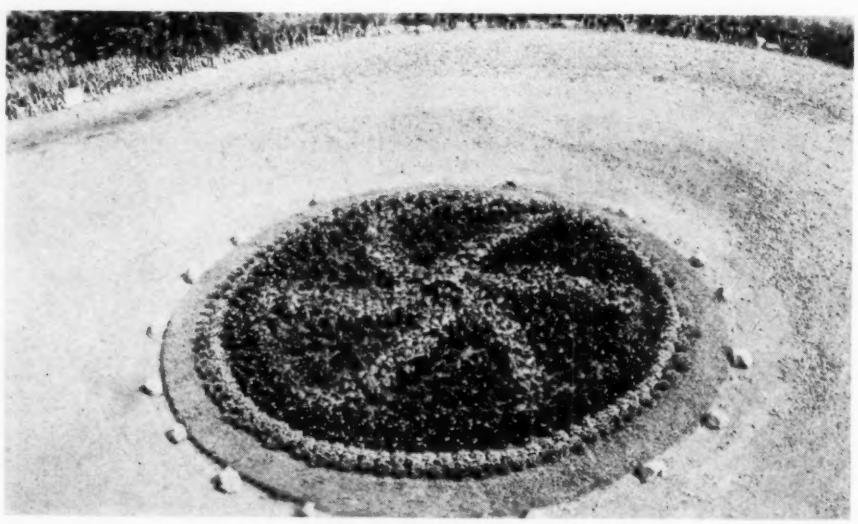
chopped up before serving, or made into a relish. Only the smaller and more tender varieties are suitable for slicing. The more perfect tomatoes may be reserved for salads for the private patients.

The season during which the hospital can count on being supplied with fresh vegetables may be stretched several months depending, of course, upon the climate. Winter cabbages grown in the Muhlenberg gardens are stored away late in the fall as are also carrots and beets.

Too much discouragement must not be felt over inadequate soil conditions. It is surprising what can be done with the poorest kind of land. Part of the property which now comprises the Muhlenberg farm was formerly swamp land. This was sown with soy beans with very good results.

There is extra labor when the hospital takes up gardening seriously. Fresh flowers mean work on the outside if they are to be properly cultivated and maintained. When used inside to decorate the reception offices and the wards, they demand constant attention. Fresh vegetables, too, need close supervision from the time the seed is planted until they are served on the patients' trays. It all creates good will, however. Making the hospital grounds a beauty spot in the community arouses interest on the part of the public. Serving fresh vegetables from its own farm likewise reflects credit upon the institution.

It can be accomplished profitably, too. With the greatest success, perhaps, when it becomes an avocation on the part of the superintendent.



A striking feature is the use of beds and borders so arranged as to provide bloom throughout the greater part of three seasons.

Following Up Patients

By H. ARCHIBALD NISSEN, M.D.
Boston

THE September, 1934, issue of The MODERN HOSPITAL published an article by Dr. Otho F. Ball entitled "Distinguished Service in the Hospital: A Stimulus to Progress." Recent personal experience in connection with a survey of chronic disease suggests one form of "distinguished service" which the hospital has not offered heretofore. This service consists of a yearly examination of every discharged patient, to be carried on as a follow-up department of the hospital.

The follow-up idea is not new. E. A. Codman first stressed its importance[1], and credit is due to him for what has been done along that line in the past twenty years. However, Codman's interest was in surgical end results only, and subsequent attempts at follow-up have been limited according to his plan to but one aspect of the patient's problems. Sporadic intermittent check-ups have been made and repeated over short periods of time. These check-up methods have been financed and carried on by one or another hospital service or by individuals interested in some phase of disease, but not by the hospital as a necessary routine.

A follow-up system, to merit the term "distinguished service," must be incorporated as an integral part of hospital administration, and must function as a definite department. As such it can render valuable service to the hospital, to the community, to the physician and to the patient. "Continuous follow-up" is used advisedly. To accomplish its aim, a check-up of each patient must be made yearly throughout that individual's life. The data obtained must be charted comprehensively and tabulated for future analysis. In this way accurate information as to the natural course of disease can be obtained.

Whereas years must pass before sufficient facts have been amassed for complete analysis of the life course and the interrelationship of various systemic involvements in one individual, the hospital establishing a continuous follow-up department as outlined may expect certain immediate yearly results. Its knowledge of each patient's physical, mental and emotional problems, as gained by the follow-up system, will engender a more harmonious spirit than had formerly existed between it and the community it serves. Final analysis of the accumulated material will demonstrate the value of the yearly check-up in preventive medicine.

Such a hospital service is actually in the realm of clinical research, corresponding to and paralleling laboratory research. By its means therapy may be correctly evaluated in time, probable hospital bed requirements more accurately estimated, friendly relations between hospital and community established and the quality of work improved.

A follow-up department should be directed by a competent member of the hospital staff with adequate personnel to assist in the work. The director should be a man of investigative make-up, and one able to reach logical and intelligent conclusions impartially and impersonally. In his department, the patient will be reviewed as the composite of all the different parts of the body, and the balance maintained between the relative importance of each systemic disorder.

Three methods of follow-up are possible—the yearly personal check-up, report from another

A distinguished service to meet the newer demands that face hospitals is here suggested in the development of continuous follow-up departments in all hospitals. Benefits accruing from such a service might be as follows: first, the possibility of accurate evaluation of therapy; second, the study of the patient as an entity rather than as one single system or organ; third, arrival at conclusions regarding prognosis, diagnosis and treatment based on material gathered carefully over a long period of time, instead of on inaccurate, insufficient data; fourth, service by the hospital to the community as a bureau of information on physical and mental health

institution and a questionnaire answered by the patient. The first is the only satisfactory method. The yearly check-up should be made at the hospital unless the patient is unable to be brought in because of physical disability. In that case, a home visit will be necessary. The first step in the examination should be an unhurried, uninterrupted interview between physician and patient, during which interview the psychical reaction of the individual may be studied, and his motivation for living understood. No second-hand report of emotional, domestic, social or physical difficulty should be accepted. The physical examination must be thorough, and must be accompanied by such laboratory and x-ray measurements as have been proved of value. Radiograms should be taken to show vascular changes, cardiac enlargement, chest and gastro-intestinal pathology, and joint changes. Laboratory tests of the blood, kidney function and the physiological sugar behavior should be made. Photographs should be a part of the check-up.

Evaluating Treatment

Treatment forms no part of the function of a follow-up department, but evaluation of treatment is an important feature. If a patient is under medical care the report of the examination should be sent to the doctor or hospital in charge of the case at that time. If he is under no other care, and certain pathologic changes are discovered which demand treatment, these should be discussed with the patient and recommendations made.

The charting of the findings each year must be carefully done and tabulated in accessible form. Positive signs of pathology should be recorded. Punch system records can be used if numbers justify the expense. For small groups of follow-up, card tabulation can be made. In addition, a chart for following the yearly life course of each patient may be appended for study. The yearly examination will show the student that the majority of patients follow four definite life courses which have been termed Courses A, B, C and D[2 3].

Many objections will be offered by those not in sympathy with a continuous follow-up plan. The first objection raised will be that of expense. Research always calls for initial expense. This expense ultimately becomes an investment from which hospital, community and patient may benefit. Such a department is to the hospital the equivalent of a bureau of vital statistics, and as such its value is self-evident. The expense can be moderate if the department is run efficiently. A follow-up department equipped to handle five hundred patients can be run for approximately $5,000 a year. This assumes that the staff is sufficiently interested to give its services.

Impracticability will be the next objection. In a small hospital the plan as outlined can be followed practically, and will prove its value within a year. A large hospital offers naturally more problems. For instance, a hospital admitting 20,000 patients in one year would find it impossible to follow such a number of individuals without an immense addition to the staff. Selection of a small group for follow-up will be necessary as a beginning—possibly indefinitely. Such a group however should be chosen without preconceived ideas, but impartially by some arbitrary selection scheme — every tenth or twentieth admission.

"Practicality" and "expense" dictate limiting follow-up service at all times to a specialized group. "Research" urges that it is limitation to a specialized group that defeats its ends and clouds with uncertainty the exact point at which, and the reason why, an individual becomes a member of that specialized group.

Duplication of effort and double contact are bogies of a social service department. There are few patients who have not visited innumerable hospitals, doctors and out-patient departments in the course of their medical shopping. Obviously, each of these hospitals cannot follow the same patient. One hospital must carry on the yearly check-up irrespective of the others. Cooperation between hospitals will greatly lessen duplication.

Central Bureau Is Helpful

Another means of avoiding duplication in follow-up is to have a central bureau (city or state) in which each patient and the institution following him are listed. Such a bureau might well be connected with the department of public health, which should be a link between hospital and physician.

A further difficulty which may arise is personal feeling on the part of some member of a staff. There is always the individual in a group who interprets as personal criticism an unbiased appraisal of fact. Before a newly established follow-up department can function smoothly, gradual education of hospital and staff is vital.

Another potential objection is the private physician's fear that a hospital free check-up of patients may interfere with his income. Temporarily there may appear to be a slight decrease in the individual doctor's income, but in the long run his financial returns should be increased.*

*This article is also published by mutual agreement in the New England Journal of Medicine.

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Packer Hospital Flexible in Design

By H. E. BISHOP
Superintendent, Robert Packer Hospital, Sayre, Pa.

THE history of the growth and development of Robert Packer Hospital, Sayre, Pa., like that of many other hospitals, is most interesting. However, suffice it to say that taking inventory of what existed in 1926 we found a total of about 225 beds, eighty of which were in modern, fireproof buildings and the remainder in one and two-story frame buildings; a modern four-story nurses' home; a laundry, and a power plant.

The specific conception of the new building just completed was developed in 1926 when a clinic, or diagnostic building, was required. The clinic, so integral a part of the whole scheme, was located to form an entrance to and an administrative and diagnostic building in connection with a future hospital building.

In May, 1933, fire destroyed the frame building on the site of the proposed new building. This necessitated some action. The 1926 conception was slightly modified and construction began.

The early triumphs and mistakes in expansion played a great part in the decisions made. Then, in spite of or because of these triumphs or mistakes, the program included 100 private and semiprivate room beds and 150 ward beds, surgery, kitchen and receiving departments. All beds in nonfireproof buildings were to be eliminated. Nurses' quarters, interns' quarters, obstetric and children's departments, power plant and laundry did not form a part of the new building except that it was necessary to extend or connect the new building to such existing portions of the group.

The bed capacity of the hospital is as follows:

New Building

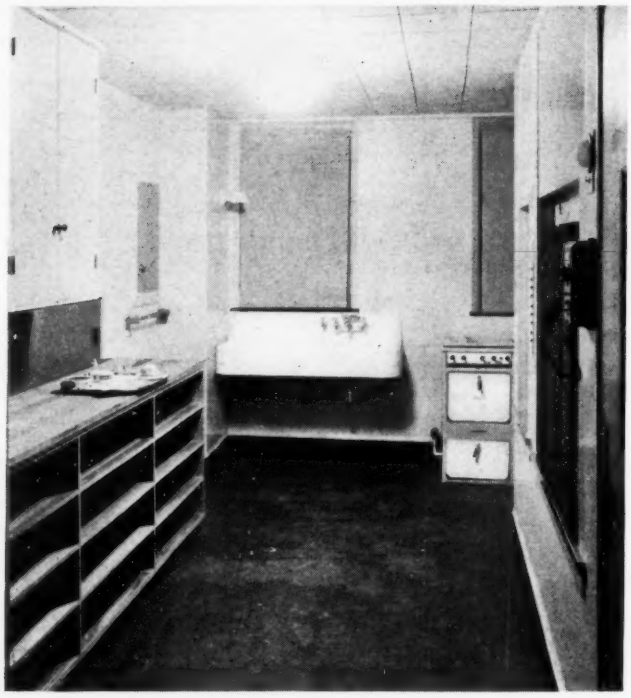
Private and semiprivate rooms	100
Wards	130
Addition to obstetric and children's building — wards	20

Existing Buildings

Obstetric and children's building — private rooms and wards (not including bassinets)	45
Private pavilion — private rooms	35
	330

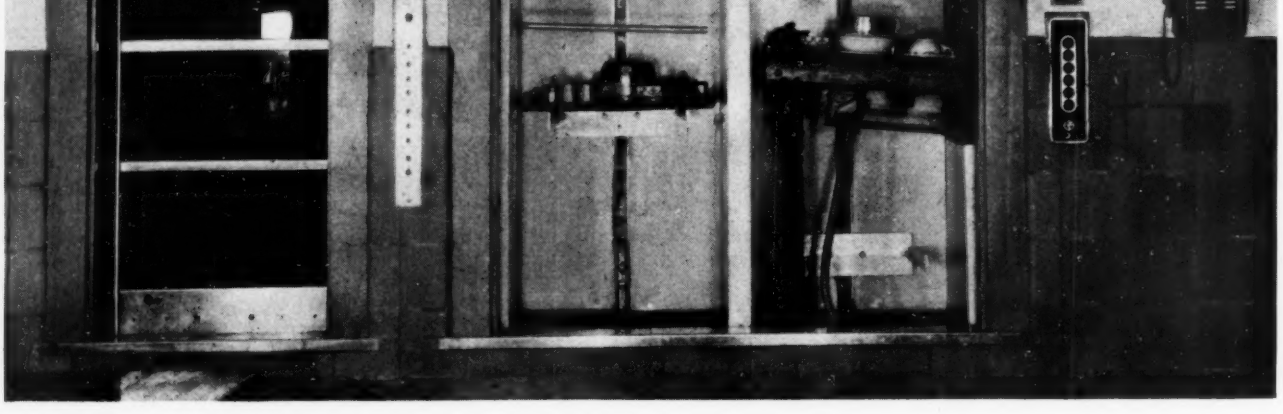
The program required the ratio of private room beds to ward beds of about 2 to 3 and since a multi-

Above, gravity conveyor in dishwashing room. Gravity conveyor takes trays at automatic unloading station on tray conveyor and carries them to soiled dish tables. The tray at the extreme right is just emerging from the tray conveyor.



The picture at the left shows a serving room on a bedroom floor. At the extreme right is the opening to the tray conveyor and dumb-waiter. This arrangement is carried out on all the bedroom floors.

Below, kitchen side of tray conveyor. Left to right: dumb-waiter opening, dumb-waiter push buttons, tray conveyor opening, tray conveyor control buttons, telephone to each floor. The tray conveyor opening shows both "up" and "down" side.



The ground floor is devoted to kitchen space and various dining rooms.

Thomas Ellerbe Co., Architects, St. Paul, Minn.

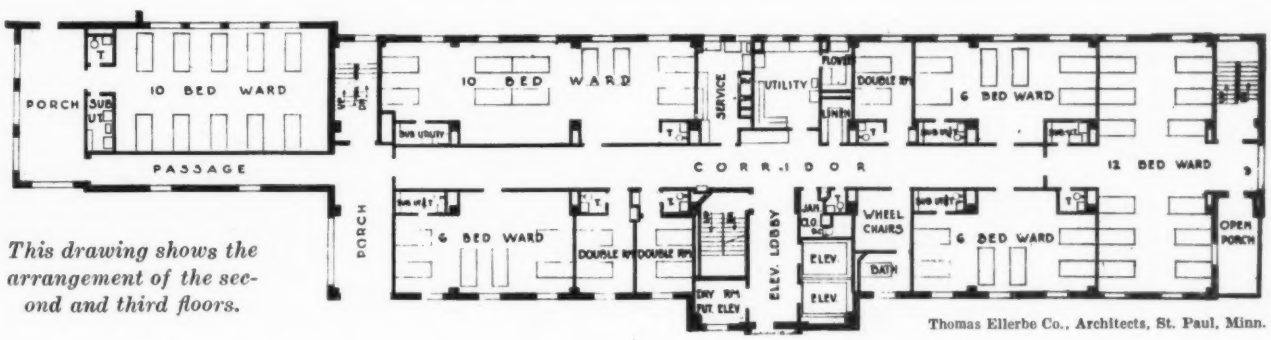
story building seemed more practical, a plan to superimpose private room floors over ward floors was accepted. In the wards consideration was given to the segregation of men and women and the space was then subdivided for medical, surgical and other facilities. In order to obtain the maximum usable bed capacity, the wards were made small, thus increasing flexibility and making it possible to utilize beds for surgical or for medical cases. In this way it was not necessary to provide for each section a peak bed capacity but only to provide a normal capacity. This separation into departments is not particularly apparent from the plan but is none the less real in the administration of the building.

In order to superimpose private room floors on ward floors a unit was developed consisting of two rooms each of sufficient size for two beds and each with its own toilet. By including both of these rooms in one big room and eliminating one toilet, a four-bed ward is obtained. On the private floors by a slight shifting of partitions, a commodious private room and a minimum size private room were obtained in one unit. These two-bed rooms are not excessively large when used as private rooms.

The toilet in each room or ward plays an important part in the simplification of the nursing service. The toilet has bedpan lugs and is equipped with a bedpan washing hose; also each toilet room contains rubber lined racks or cabinets for the storage of bedpans, urinals, washbasins and smaller utensils. In the larger wards a toilet is separately provided for the patients and a sub-utility room is provided for the nurse. This arrangement in both wards and private rooms then makes the utility room a "clean" utility room, especially as the janitor's closet has been increased over its traditional size to provide amply for all housekeeping services. At first glance it might seem that the service areas, although located centrally are a bit too far removed from the most distant beds, but in view of the fact that a major portion of the services are taken care of locally, this objection cannot be sustained as the remaining services are better concentrated than decentralized.

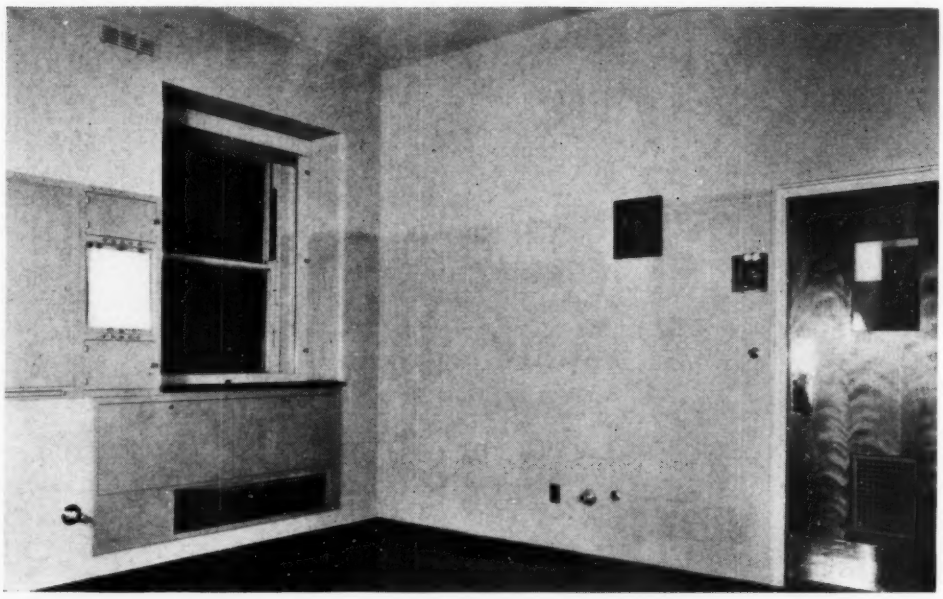
In addition to the usual nurses' call system, wiring has been installed complete for the addition of an intercommunicating telephone system. However, since the actual value of this system in saving steps for the nurse is in question, only one floor has been completely equipped with the patients' instruments and the nurses' telephone set.

Some features have been added for the patient's comfort. In the private rooms a two-channel radio system is available for either loud speaker, head set or radio pillow. Telephone service is also available in the private rooms and nine of the private rooms are air conditioned with a unit air conditioning machine. The lighting in the private rooms is accomplished with an indirect bracket at the head of the bed. Each bedroom, as well as the corridors, has a night light installed near the floor and these are operated by silent mercury switches. The features for the patients' comfort in the wards are similar to those in the private rooms except that no



This drawing shows the arrangement of the second and third floors.

Thomas Ellerbe Co., Architects, St. Paul, Minn.



Concealed air conditioning apparatus. Grille under and grille over window and control instrument panel next to door are the only visible evidences of air conditioning apparatus in any of the operating rooms.

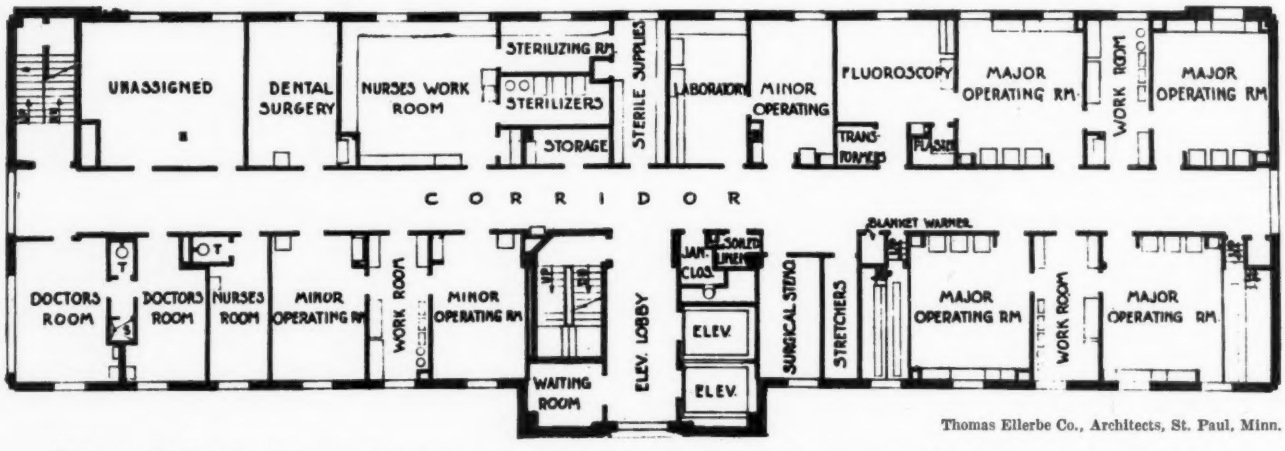
telephones are provided and a loud speaker on the radio cannot be installed, but head sets or radio pillows are available.

The feasibility of a multistory building is dependent on the vertical transportation. The elevators are concentrated at a central point and at present two 500 feet per minute elevators of the latest type are installed, one for manual operation and the other with automatic operation. A third shaft for a future elevator is also provided in the event that these two elevators should prove inadequate. The manually operated elevator will be used for patients and visitors while the automatic elevator will be used for employees and service.

The concentration of these elevators may appear to cause congestion in the elevator lobbies but it must be considered that the peak traffic loads for each type of elevator service does not fall at the same time. In addition both types of elevator service can be combined on one elevator during an emergency shutdown of either elevator, or both used for the same service at peak load times. A dumb-waiter and continuous two-way chain conveyor for trays are provided in conjunction with the food service.

The debate as to the type of food service best suited for hospitals has never been satisfactorily concluded and it probably never will be, but will remain a problem to be settled by the individual likes and dislikes of the superintendent and the dietitian. In order to avoid fixing too definitely for all time to come the solution to an administrative problem, the serving rooms on each floor and the communication with the kitchen are laid out to function either for the distribution of trays served centrally in the kitchen or for the serving and distribution of trays with food delivered in bulk from the kitchen. In either event, however, central dishwashing is an advantage with a two-way conveyor which automatically discharges into the dishwashing room the trays that are placed on it from any floor.

The kitchen plan itself hardly permits such indefinite policy. The trays for the three private room floors will be completed in the kitchen and delivered to these floors on the tray conveyor, while the food for the wards will be delivered in bulk in electrically heated food carts via the service eleva-



Thomas Ellerbe Co., Architects, St. Paul, Minn.

The seventh floor is given over to surgery. It contains six major operating rooms, each of which is air conditioned.

LIST OF SPACE ALLOCATIONS IN THE MAIN BUILDING

Tenth Floor

Elevator machine room.

Ninth Floor

Air conditioning equipment room.

Eighth Floor

Solarium.
Promenade deck.

Seventh Floor

Surgical floor:
8 Operating rooms which include:
Six major operating rooms, two of which have view stands to accommodate each a clinic of 30.
One minor operating and anesthetizing room.
One dental operating room.
3 Work and sterilizing rooms (between operating rooms).
1 Dressing and preparation room.
1 Sterilizing room.
1 Sterile supply room.
1 Nurses' dressing room.
1 Chief surgeon's dressing room.
1 Surgeons' dressing room.
1 Surgical stenographer's office.

Sixth, Fifth and Fourth Floors

Private and semiprivate bedrooms.
Solarium.
Open porch.
Serving kitchen.
Utility room.
Flower room.
Janitor service room.
Wheel chair "parking area."
Patients' bathroom.
Nurses' toilet.
Private duty nurses' locker and dressing room.
Each bedroom has its own toilet facilities and in addition several have baths.
Linen storage room.

Third, Second and First Floors

Wards of various sizes to accommodate from 2 to 12 beds.
Open porch.
Solarium.
Serving kitchen.
Utility room.
Flower room.
Linen storage room.
Janitor service room.
Wheel chair "parking area."
Patients' bathroom.
Nurses' toilet.
Each ward has its own toilet facilities and in addition the larger wards have a utility room.
The second and third floors each have a bedroom for the care of postoperative psychosis.

Ground Floor

Kitchen:
Bakery.
Vegetable preparation room.
Diet kitchen.
Bread room.
Central dishwashing room.
Nurses' cafeteria.
Doctors' dining room.
Help's dining room.
Receiving room for both culinary and general supplies.
General storage refrigerator.

Basement

Mechanical equipment room.
Kitchen storage.

tor. Special diet trays will be completed in the diet kitchen and delivered to the floors either on the electric dumb-waiter or on the tray conveyor. Circulating ice water is piped to each diet kitchen as well as to corridor fountains on each floor.

The entire seventh floor is given over to surgery. It contains six major operating rooms arranged in pairs with sterilizing and workrooms between. Two of the major operating rooms have clinic view stands, accessible only through the corridor. Adjacent to one of the major operating rooms is a combination fluoroscopic and plaster preparation room to be used in conjunction with orthopedic surgery. Operations requiring complete operating room technique will be conducted in this major operating room and the plaster will be brought to this room from the adjacent plaster room. Simple casts will be prepared and applied in the fluoroscopic and plaster room. In addition to these there is also a dental operating room and a minor operating room. The nurses' workroom (dressing preparation), the sterilizing room and the sterile supply room form a unit in the center of the building. All dressings, the bulk of the instruments and utensils used in the operating rooms will be autoclaved in this sterilizing room.

The six major operating rooms are air-conditioned with a central system. The conditioning unit is on the ninth floor and supplies conditioned air to each room. No air is recirculated. A separate exhaust system takes the air from the operating rooms through the workrooms. This system includes heating, cooling and humidification. The last is most important from the standpoint of safety from static spark in the use of anesthetic gases.

The selection of material throughout was made after careful consideration of ease of maintenance and also elimination of noise. Corridors have rubber floor and base, glazed brick wainscot and acoustical material ceiling. Service and utility rooms have asphalt tile floor, slate base, acoustical material ceilings. Toilets have tile or terrazzo floor and wainscot and acoustical material ceilings. Bedrooms have soft floors (rubber, linoleum or asphalt tile), terrazzo border and base and some private rooms have acoustical material ceilings. Operating rooms have rubber floors and matt glazed terra cotta wainscot 7 feet high.

In order to simplify window washing, special pivot windows are installed. These operate normally as double-hung windows but in addition can be pivoted in to wash the outside of the glass from the inside of the room.

What Others Are Doing

"Comment Card" Found of Practical Help

Berkeley General Hospital, Berkeley, Calif., has recently adopted the practice of sending a "comment card" to each patient after he is discharged from the hospital, thus giving him the opportunity to respond at his leisure and without being influenced by hospital surroundings.

The card asks for comments, criticisms and suggestions and reads in part as follows: "We hope the hospital has helped you. However, if we did not succeed in pleasing you or in rendering what you considered the best of service we hope you will tell us. If, on the other hand, the service was good or if you received any unusually fine attention from any of our staff, we should appreciate hearing of this also, so that the work of these people may be properly recognized."

Alfred E. Maffly, superintendent, says that the comments have given the hospital an interesting index of the type of service it is giving and have offered many valuable suggestions and constructive criticisms. The returned cards are carefully studied, the hospital personnel favorably mentioned by patients are complimented and complaints are analyzed and answered. The cards are then filed in numerical order in the record room and form the final entry of the patient's hospital record.

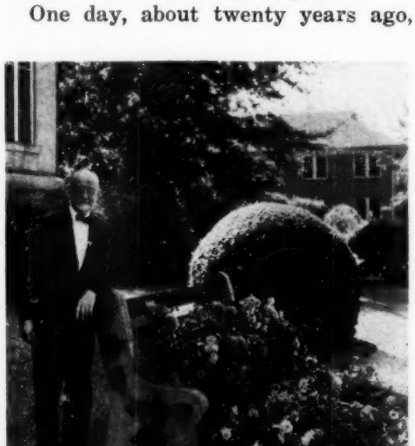
The attached reply card is self-addressed and requires no postage stamp; consequently a large percentage of cards are returned.

Ten Thousand Bouquets a Year

Once upon a time a vessel set out upon a dangerous voyage. It finally reached the dreary shores of America. The vessel was called the *Mayflower*. On this boat was one John Howland and also Elder Brewster who had a Bible. During a storm on the voyage all hands went below decks but Elder Brewster left his Bible exposed to the weather. John Howland went to fetch it. He was swept overboard but grasped some rigging and was finally pulled on board again still clutching the Bible.

That was a lucky day for the United States when John Howland was pulled on deck. Like most men John Howland married and was the father of children. One of his descendants had infantile paralysis but was elected President of the United States. His name is Franklin D. Roosevelt. Another became a great singer. Her name was Nordica. Another was born in Greenville, S. C. His name is Arthur G. Gower and below is his picture.

One day, about twenty years ago,



descendant Gower took a bouquet of home grown flowers to a sick person. It cheered her very much. As John Howland clung to the Bible, descendant Gower clung to the idea that he could possibly scatter much cheer among the sick by sending them flowers. He began to fix up little bouquets for the hospital sick.

Of course, to see that the job was done well, John-Howland-like, he carried the flowers to the patients himself. He had a sunny smile, a cackling laugh, a deep faith, a tender love of folks and a desire to be helpful. One year he gave away as many as 10,000 small bunches of flowers to the sick. He has continued this work for twenty years, and has given away 200,000 presents of flowers. Almost all of the flowers he has grown in his own garden which he worked himself. He gets up at 5 a.m. Sunday mornings to arrange his flowers, for they must be distributed so that John Howland's descendant may get to church on time. The preacher needs the inspiration of his presence, as well as the sick.

Once a luncheon club in his city wanted to honor a leading citizen. He was chosen. He had lost his money. He is not a member of the chamber of commerce, of a civic club, or of a fraternal organization. He was chosen because he is an aristocrat of God.

Research Work on Vaccine Wins Favorable Comment

An unusual type of work for a hospital without university connections has recently attracted wide attention to Toledo Hospital, Toledo, Ohio. The story may best be told in the words of George W. Wilson, superintendent:

"One of our hospital activities promises to be of much benefit, not only to our city but to the country as well. This hospital has a research department. The original endowment gift was small but the fund has grown through the accession of gifts and the interest of hospital friends. The pathologist, Dr. Bernhard Steinberg, has been working for some time on a vaccine to prevent peritonitis. Recently it was announced that the vaccine had been successful in preventing peritonitis in 99 per cent of the cases in which it was used. The discovery is being favorably received in medical circles.

"As Toledo Hospital is not connected with a university or a research institute, we believe such work as this to be an outstanding community service. It has large possibilities of application and extends the influence of hospitals in general."

Special Slip Reports Unusual Occurrence

An excellent method of eliminating complaints and also forestalling more serious contingencies arising as lawsuits is revealed in Alameda County Hospital, Oakland, Calif. This is just as practical for the small hospital as for the large. Briefly, it is an "unusual occurrence" slip. This blank, which is business letterhead size, is divided into three sections in which the nurse, the doctor and the superintendent of nurses can describe anything out of the ordinary which may happen to any patient.

Should a patient fall out of bed or should anyone get up from bed without such privilege and suffer a fall, the incident is reported fully. The nurse recounts the occurrence as it came to her attention. The doctor describes the state in which he found the patient, and the supervisor of nurses notes her participation in the affair. The report

thus completed is sent immediately to the office of Doctor Black, the hospital superintendent.

The family of an elderly man, who was receiving hospitalization, for example, registered a complaint about a bed sore the patient had developed despite the fact that he had been in the hospital but a day or two. The filing of an "unusual occurrence" slip in Doctor Black's office had already preceded the complaint, however. This recorded the presence of the sore on the patient's back which he frankly admitted was the result of a burn which he received from a hot water bottle before he entered the hospital.

Insurance Policy Saves Employees' Money

Economic security is just as important to hospital employees as to those in any other occupation. The better hospitals, of course, have always prided themselves on helping their employees in time of trouble. But if the hospital itself was also hard pressed this was not easy.

To meet this situation, at least in part, Presbyterian Hospital, Chicago. some time ago took out group insurance policies on its employees. Under the provisions of these policies employees earning $50 a month or less have a $500 life insurance policy and a sickness and accident policy paying $7.50 a week for thirteen weeks. The employee pays $0.80 a month, which is deducted from his pay and the hospital pays an equal amount.

The benefits for the employees earning $50 to $100 are $10 weekly for disability with a $500 life insurance policy. Their premium is $1 a month. The group earning over $100 have a weekly benefit of $15 and life insurance of $1,000 at a cost to them of $2 a month. Department heads have no sickness and accident insurance but have life insurance policies of $2,000.

The employee under this plan pays a little less than one-half as much as he would if he insured himself as an individual. No medical examination is required. While the insurance terminates if the employee leaves he is entitled to convert it without a medical examination into one of the ordinary life policies at the current rates at his attained age.

The plan has been in operation since July 1, 1932. In the opinion of Asa Bacon, superintendent, it has done much to relieve employees of worry during the depression.

Activities That Win Good Will for This Hospital

Vassar Brothers Hospital, Poughkeepsie, N. Y., as part of its contribution to community welfare has for the past two winters cooperated with the Poughkeepsie Unemployment Committee in giving physical examinations to unemployed men on relief work in the city. This work is carried on in the out-patient department by physicians connected with the hospital.

This is only one of the ways in which the hospital is building up good will for itself. The chief dietitian has been doing her part by addressing parent-teachers associations and other groups on their food problems. This winter members of her department will deliver a series of six lectures on nutrition to members of the Dutchess County chapter of the Red Cross. She also advises the woman in charge of the nutrition work in some ten nursery schools that have been established in the community under the temporary emergency relief administration, and cooperates with the Poughkeepsie emergency relief bureau in working out dietary problems.

J. J. Weber is the superintendent of the hospital.

Field Worker Proves an Asset

The financial field secretary of the Lutheran Hospital, Brooklyn, N. Y., has just completed a year of service at the institution, the results of which have proved of considerable value.

When this field representative was appointed, the hospital had in mind two types of duties. One was the cultivation of a group of annual contributors. The other was the collection of old hospital bills and unpaid subscription pledges. In addition to these two main tasks, he was to arrange for suitable publicity in the community.

Augusta E. Abel, superintendent, writes as follows regarding the work done:

"It really is a bit early to evaluate the success of the annual contributions for we have yet to canvass this group for their first annual installment. However, any statement of results must take into consideration the present economic conditions which have caused a decided decrease generally in the number of the charitably inclined.

"We are able to report remarkably successful results from personal solicitation of those who are indebted for hospital services rendered or who owe money on subscription pledges.

"In the matter of publicity, the financial field secretary has made brief addresses before various women's clubs and mens' organizations. He also is instrumental in arranging and distributing the bimonthly bulletin which contains news of the hospital. He is active on committees arranging for entertainments and benefits for the hospital.

"His work is carried on under the supervision of the board of trustees to whom he reports monthly and to whom he is responsible."

Uniforms for the Personnel

In order to give a dignified and neat appearance to employees, the State of Wisconsin General Hospital, Madison, Wis., has a uniform which is worn by all student orderlies, night clerks, elevator operators and similar personnel.

The uniform consists of blue trousers, black shoes, a white shirt and a black bow tie. No coat is worn unless it is needed. Then a blue coat to match the trousers is provided.

This uniform does not require any additional expenditure either on the part of the hospital or the personnel. The clothes are simply a part of the individual's normal wardrobe. This standardization of attire has materially increased the efficiency and improved the appearance of the various employees.

Probably you can think of one or more practical ways to save time or increase efficiency. The Modern Hospital will welcome your ideas to put before other hospitals

"They Play With You Here"

By MABEL W. BINNER
Superintendent, Children's Memorial Hospital, Chicago

PERHAPS every hospital superintendent has been in the depths of despair at some time or other because of the impossible task of keeping his institution up to date on equipment of various kinds. This has been particularly true during the past few years.

By the time the last model in drinking fountains has been installed and before the water is turned on a newer model is on the market and the former model is declared a menace to public health. The medical staff, x-ray department, physiotherapy department, nursing department and some ten to twenty other departments are clamoring for things, things, things. In bewilderment the superintendent sees the instruments or equipment which were the last word in 1932 abandoned in 1934. He breathes a prayer of thanksgiving that he cut the original order of twenty-four down to two, as these two now are on the scrap heap all too soon. As the demands pour in he wonders why it is impossible to irrigate an eye successfully from white enamel basin No. 738, and listens to reasons why nothing will do but white enamel basin No. 791.

With every new group of interns all items, from quartz lamps and oxygen tents to standardized stock supplies of spinal puncture and hypodermic needles, are always the wrong kind, each intern feeling that only the types in use at Johns Hopkins or some large medical center are fit to use. We expect new models on everything yearly, we are increasingly dependent upon things. We are losing our resourcefulness and much of our ability to do good work regardless of equipment.

Because of the emphasis placed upon "things" and cold, hard facts, such as budgets, perpetual inventories, cost per thousand pounds of steam, health insurance for employees, the superintendent can easily lose his perspective so completely that the only reason for the existence of the hospital is forgotten, that is, the patient.

In one hospital, where the chief of staff was a terrifying and lordly individual, the probationers were greatly impressed by his magnificent presence. In examination the question was asked, "Who is the most important person in the hospital?" With one accord the class wrote "Dr. Blank."

If a hospital is to be distinguished for its service, and service means more than all the best

equipment combined, the patient must be uppermost in the minds of all of us at all times. When difficult problems are presented for solution, the question "How does this affect the patient?" will invariably aid one in making a fair decision quickly and surely. There is nothing in the hospital that does not affect the patient indirectly, if not directly.

It is not enough to do a good piece of surgery, a good job of nursing a patient. Individuals or groups that can contribute to making the job just so much better than it has ever been before must be called upon. An example of this may be seen in the cooperation needed in caring for the cleft palate patient. One might do an excellent piece of surgical work for the child with harelip and cleft palate and yet the patient might not survive or if he did he would still be greatly handicapped. His nutrition must first be built up through careful supervision by the pediatrician. Following the operation special nursing must be provided by someone thoroughly familiar with these conditions. The social worker must so supervise the case that adequate care is given between periods of treatment. The speech defect due to faulty habits of articulation even after repair has been completed must be corrected by reeducation over a period of months or even years. Physiotherapy must be given by a well trained physiotherapist. Massage of the healed lip and palate will improve the repair work. No resources must be left untapped when the cure or rehabilitation of any patient is at stake.

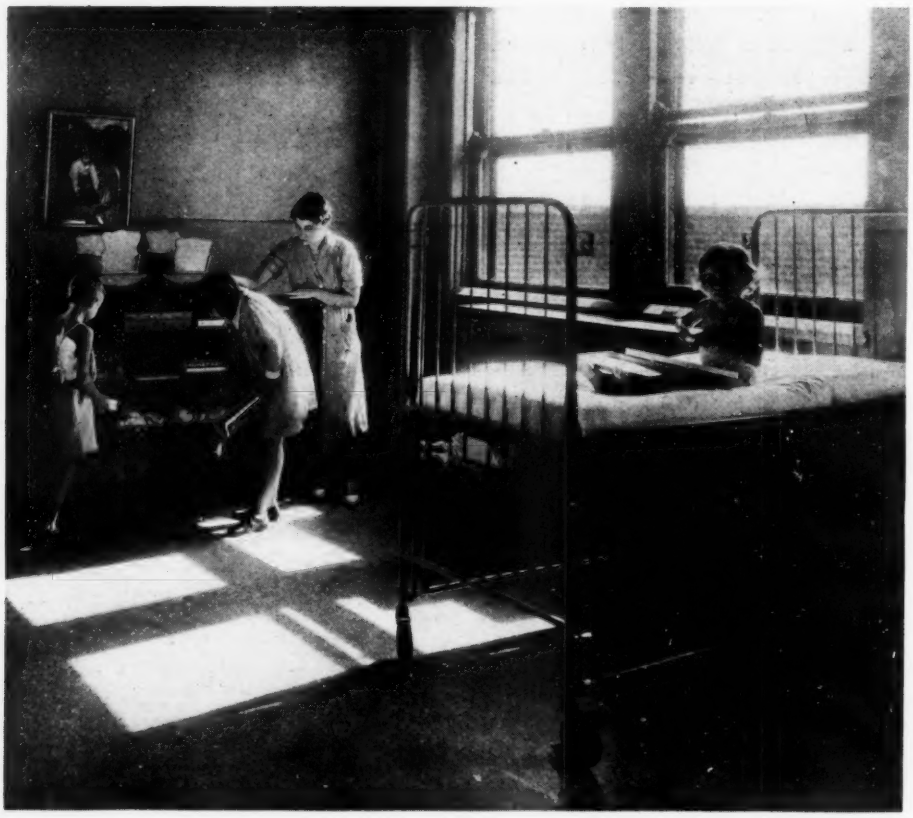
We stop at nothing when the members of our family are concerned. Exactly this same attitude toward the hospital patient must be held by the hospital superintendent. Good service cannot be given unless the personnel are carefully selected. This is true in any hospital; it is doubly true in a children's institution. Executives of adult hospitals may question the last part of this statement. There is a tendency, however, both inside institutions and out, to feel that most people can get along with children.

In the well-to-do home we all know that the cook and secretary are selected with greater care than is the nurse maid. I frequently receive letters of recommendation stating that the applicant for a position is lacking in tact, or is somewhat quarrelsome or overly sensitive, but "we believe she would do satisfactory work with children." Why? Because the child, particularly the younger child or infant, is not articulate regarding the unsatisfactory service given him. For this reason we must be sure in selecting personnel that the intern and nurse, or even the maid and porter will be as considerate and attentive to the most helpless child's needs at all times as they would be to the most exacting and cantankerous adult patient.

Doctors and nurses are notoriously difficult to deal with when they are ill or when members of their families are ill, and yet they can glibly say of a patient, "Oh, she isn't very sick." I saw a young patient's chart at one time on which was recorded a rectal temperature of 106 degrees and this comment, "Patient not acutely ill." Well, perhaps the patient was not acutely ill — but would that very young doctor have made the same entry had the temperature been that of his three-year-old son?

Unless we can impress upon every employee the

Group of student nurses at Children's Memorial Hospital receiving instruction in playing games that will be amusing to children.



The toy cupboard is filled with various games and toys which provide a great deal of fun for children confined to the hospital.

Fun now replaces fear on "tonsil morning." The children are gathered together on a sun porch by the "play lady" where various games are employed to keep them happily occupied.

The library cart with the librarian furnished by the Chicago Public Library is a welcome visitor on the wards.

fact that the only reason for the existence of the hospital is the patient, our institution will never reach the standard it should. We must impress upon them again and again the fact that we expect these patients to have the same care that they would like for their little brothers and sisters, nieces and nephews or sons and daughters, as the case may be. They may be interested primarily in their medical education or nursing education or in work as a means of livelihood. All of these interests can become an asset to the institution but must never be allowed to interfere in any way with the welfare of the patient.

Our responsibility to sick children is a serious one. The adult patient usually enters a hospital voluntarily, if not enthusiastically. The child is brought by persons responsible for him; he is at their mercy and at ours. This is a tremendous challenge and cannot be taken too seriously. To be a child is hazardous; one wonders that the adult state is ever reached. Children pour into every children's hospital because of fractures, burns, injuries to eyes and ears, because of swallowing foreign objects, buttons, pins, victrola needles, drinking or eating poisonous solutions or tablets, while the sorrowful parents are consoled by sympathetic relatives and neighbors. However, let one minor accident happen in a children's hospital handling daily between 400 and 500 patients and the eyebrows of the world are raised and there is no consolation for the superintendent from the nonsympathetic relatives and neighbors.

Children, too, come to us in the formative period. They are developing rapidly, each day brings vast changes in them, whereas the adult is in a fixed state as to his education, habits, emotions and character. We can do dreadful things to a child during even a twenty-four-hour stay; we can change his entire outlook on life for better or worse during an eight-months' stay in a hospital. Any program for a patient's care naturally begins with excellent medical and nursing care. In addition to that we must safeguard him in every way, physically and mentally. His day should approach the day of a normal child as nearly as is possible under the circumstances. The following are only a few of the many points to be checked in safeguarding the patient physically:

Equipment and apparatus — the bed side must be high to prevent the patient falling out of bed; infants' high chairs may be cut down to "low chairs"; stairways, clothes chutes, incinerators, windows, must be considered as hazards and adequately guarded.

Foods — bones, fruit pits and seeds should be removed as possible hazards; care should be taken regarding utensils on trays, drinking tubes.

Drugs — all solutions and drugs should be out of reach. In our hospital no poisonous hand solutions are allowed on wards.

Toys — all toys should be censored and small objects, marbles, pegs, doll and animal eyes, sharp edges, such as are on tin toys, and celluloid toys easily broken should be taboo.

Wholesome occupation must be provided for every waking moment for all children well enough to be active to any degree. At the Children's Memorial Hospital, Chicago, the morning hours are covered by three school teachers provided by the board of education. The Sunbeam League furnishes a kindergarten teacher in the afternoon. There is a recreational director or "play lady," who is a most popular person. One cannot go through the wards without having some child inquire, "Have you seen the play lady? If you see her tell her to come here." She helps plan games and other entertainments.

Nurses Are Given Special Training

The library cart with the librarian furnished by the Chicago Public Library is also a welcome visitor on the wards. These services can be important in themselves but unless they are looked upon as an integral and vital part of the organization they will not produce the maximum results. At the Children's Memorial the play lady does not limit her work to the child; books are not the librarian's property alone. The nurses are taken along with this program. They are instructed so that they know how to play with the sick child. Play would not reach far if it could not be continued in the absence of the play lady. Games can be played while baths are being given. The children can carry on when neither nurse nor play lady is in the room. The nurses are taught how to help select books for the children, how to advise parents when the librarian is not on duty.

More important than any of these services is the idea behind them, of providing pleasant surroundings, minimizing the unpleasantness of disagreeable experiences. One example will illustrate this point. About thirty-five to fifty ward patients a week are admitted for tonsillectomies. Snatching these children away from their parents, thrusting them into this noisy, bloody experience cannot be termed so lightly a "minor operation." Any psychiatrist can tell you the lasting damage which often follows an ordeal of this kind. These children in groups of fifteen or more come to us three times a week, ranging in age from two to twelve. In the past their apprehension grew as the waiting period lengthened. The last child to be called was often in a state of extreme nervousness, sometimes bordering on hysteria.

Now, these children are gathered together by the play lady on a sun porch removed from sight and sound of either operating room or tonsil ward. Bean bag, guessing games and various entertainments keep them thoroughly and happily occupied until the last one is called. The anesthetic is quietly taken, the recovery afterward is noticeably more tranquil, as compared with the pandemonium which used to characterize tonsil day. Our fame has grown for the children spread the word "They play with you there."

While this work is not carried directly by the play lady to the private patients, the attitude toward children and intelligent understanding of them is felt throughout the institution. Recently a private patient was admitted for a tonsillectomy. This had been attempted before in a general hospital. The patient had become so terrified that the parents took him home. Some time later the physician again recommended a tonsillectomy. The parents not too willingly brought him to us and, to their amazement, there was no difficulty.

Again may I repeat that our patients should receive as courteous, considerate service from every one in the institution as we would wish a member of our own family to receive. Any other standard — dividing lines, with service de luxe for one group and less tact, courtesy and heartfelt kindness for another group — will not make a hospital the fine place it can and should be. Service in every ward and every department should be good enough for the most loved member of our own family. When this type of service has been assured there will be little unfavorable criticism of our institution. If we adopt any other criteria for judging our service we are not fulfilling the trust placed upon us.

Model Articles of Incorporation and By-Laws

The articles of incorporation of a hospital should be carefully drawn by a capable attorney and should set forth the purpose and control of the organization, the act of the legislature under which it is incorporated and the period of incorporation. The articles of incorporation should be reviewed from time to time, states Sidney G. Davidson, Grace Hospital, New Haven, Conn., writing in the thirteenth edition of The HOSPITAL YEARBOOK, in order that they do not lapse and so that they may permit new activities to be undertaken as found desirable. For the hospital, a constitution is unnecessary, he states, since the basic laws are set forth in the articles of incorporation which every hospital must file with the state.

In addition to the articles of incorporation, Mr. Davidson shows the need for by-laws for the guidance of the board and administration and rules and regulations for the purpose of more detailed guidance of the administration. His article contains a complete set of model articles of incorporation and model by-laws. It also outlines the matters that should be covered in the rules and regulations.

Clouds on the Horizon

By B. C. MacLEAN, M.D.
Superintendent, Touro Infirmary, New Orleans

DURING the past decade a number of storm warnings have appeared on the sea of the voluntary hospitals. The jazz age of insane speculation and spending was at its height, however, and little heed was paid to these warnings as long as the public was willing privately to donate huge sums for the erection of new hospitals to satisfy individual, group or sectarian pride of control and to provide professional staff honors.

When the economic bubble burst the clouds became darker and during the past four years the gathering storm has been signaled by a thunder of criticism from the public. The voluntary hospital ship has bravely attempted to keep afloat financially but is now threatened either with mutiny by some members of her medical crew or with wreckage on the rocks of bureaucracy and political itch.

The medical profession has become more and more articulate in recent years against an alleged exploitation of its services by institutions. The growth of clinics, out-patient departments or dispensaries in hospitals has been one of the important developments of hospital service during the past three decades and in practically every instance such clinics were established at the request of the medical profession. Abuses have been discovered in individual instances but in the main with the intelligent application of methods of financial investigation and social service appraisal, these impositions have been infinitesimal and the same may be said of the public wards of voluntary hospitals with dispensaries.

The continued excessive output of physicians from schools of medicine, however, an output greatly in excess of the losses from the ranks of the profession, has created an economic problem which prods many a doctor to attack any system which may seem to affect his private interest.

Until recently the American Medical Association, through its bureau of medical economics and its official representatives and publications, has overlooked no opportunity to deride and obstruct the efforts of voluntary hospitals to advance a plan of group hospitalization. This attitude on the part of a great medical organization was in marked contrast to that of the American College of Surgeons.

The latter body studied carefully the periodic payment plan for hospital care, realized its possibilities in providing many persons with a means for budgeting hospital costs and gave official endorsement to it. Then medical societies here and there, ignoring the outspoken and indirect opposition of the national association, commenced to see the benefits of the group hospitalization program and approved it. Possibly we may even look forward to a more tolerant attitude towards these problems by the organized profession of Philadelphia County. The decalogue of the A. M. A. brought down at the Cleveland meeting this year, although evasive and ambiguous, is an encouraging indication of a less reactionary and more progressive policy for the medical profession.

The antagonistic attitude of the American Medical Association toward the efforts of voluntary hospitals to advance plans of group hospitalization, the claim of members of the American College of Radiology that the hospital exploits its roentgenologist, by paying him a salary and appropriating excess profits, and the paternalism of the government's provisions for free hospital care are seen by Doctor MacLean as storm signals that menace the smooth sailing of the hospital ship

Periodic payment plans for hospital care are making progress slowly, but it is here perhaps that our hope lies. We may venture the prediction that the medical profession itself after observing the practicability of group hospitalization may wish to apply its principles to medical practice. A coordinated plan to provide both medical and hospital service on a periodic payment basis, controlled by the profession and the hospitals

and with the proper safeguards, may avert the crippling of medical practice and the ruin of the voluntary hospital system.

The more militant groups here and there in the profession may, by their noise, belie their number, but we cannot overlook recent threats by them in respect to their institutional relationships. The members of the profession by their contributions in the clinical care of the indigent sick in voluntary hospitals are justly entitled to some voice in the management of these hospitals but after all the American public through philanthropy has an investment of one and one-half billion dollars in nongovernmental hospitals to provide workshops for the profession and care for the public.

At the third conference of the American College of Radiology held in Chicago in February, 1934, reports of which are contained in its Bulletin No. 1, almost every speaker dealt with the economic relationship of the roentgenologist to the hospital. In brief, the target of their wrath is the full-time system of x-ray department organization in hospitals. It is claimed that the hospital exploits its roentgenologist by paying him a salary and appropriating large excess profits. In the series of "Principles to Govern Relation of Radiologists to Hospitals" as set forth by the chairman of the commission on medical economics of the American College of Radiology, the proposal is made that the hospital should provide all apparatus and equipment, heat and light, but that all fees should be collected by the roentgenologist and that he should pay the hospital a reasonable charge for the privileges and perquisites of the department. Indeed, one speaker expressed at this meeting the opinion that the hospital should not participate in or collect the fees which the roentgenologist charges for his services any more than the hospital should do so in surgery or any other specialty of medical practice.

Let us be frank and admit that x-ray examinations are expensive and also that the x-ray department of a nonprofit association hospital is usually looked to by the administration to show a margin of profit over actual expenses. The reason for both these circumstances is that both the profession and the public, wittingly or unwittingly, demand a fee system in the hospital which makes it necessary to make up on the Ferris wheel what is lost on the merry-go-round.

A coordinated plan to provide both medical and hospital service on a periodic payment basis, controlled by the profession and the hospitals and with the proper safeguards, may avert the crippling of medical practice and the ruin of the voluntary hospital system of this country

Let us be frank and admit that x-ray examinations are expensive and the x-ray department is looked to to show a margin of profit. The reason for both these circumstances is that the medical profession and the public, wittingly or unwittingly, demand a fee system in the hospital that makes it necessary to make up on the Ferris wheel what is lost on the merry-go-round

It is idle for theorists to clamor for a cost basis charge in all services of a hospital. The patient who receives bed care at $3 a day and the doctor who attends him as a private patient must or should know that the charge is less than cost. It is probably for this reason that he regards so complacently the cost plus schedule of charges for x-ray examinations. The same may be said for such other adjunct departments as the pathologic laboratory and the operating room.

The apparent concern over the welfare and interest of the patient warrants attention but it may safely be predicted that a lowering of fees in the x-ray departments of nonprofit hospitals would draw an immediate fire of criticism from independent roentgenologists. Furthermore, the establishment of a system by which the hospital would render and charge for only a technical service would undoubtedly result in the roentgenologic interpretation being done in many instances by the attending physician and without consultation with a roentgenologist. This surely would not, in the long run, be for the best interests of the patient.

Altogether the specious claims of exploitation of professional services may with equal logic be applied to the employment of full-time pathologists, anesthetists and, indeed, staff nurses, and even the lowly hospital superintendent might ask that he be paid on a piecework but professional basis—so much per "No" for example. It is unnecessary to discuss the complexities and involvements of clinic and free services or of teaching facilities in respect to the organization of such departments.

Suffice it to say that the analogy of surgical practice is not a true one but even in the sacrosanct realm of surgery the trend is obviously towards coordination between hospital and doctor in all things that pertain to the interest and the care of the patient.

The darkest cloud that hovers over the hospital at this time is probably the political one. The much heralded New Deal has brought an occasional "deuce" to the hospital end of the table but the hoped for "full house" has not materialized and the "ante" has been raised by the purveyor of every hospital commodity on the purchase list.

It is the political and social trends rather than the economic developments, however, which may justly cause misgiving. Irrespective of party the federal government during the past fifteen years has become more paternalistic in its provisions for free hospital care and treatment. The service connected injuries and illnesses consequent to war are an unquestioned national obligation but the shameful submission of Congress to the logrolling and noisy lobbying of a minority of the electorate, the extension of unbelievable medical and hospital privileges to office desk and home duty heroes and even to senators and congressmen, and the expenditure of millions of dollars in new and enlarged institutions for the treatment of nonservice connected disabilities is a dark page in our political history.

Some of this increase is for beds for the treatment of patients suffering from tuberculosis and mental disease but much of the increase is in governmental hospitals which are classified as general. The voluntary hospitals may justifiably be alarmed in observing this extension of governmental general hospital service, for the occupancy of the former has decreased directly as the governmental hospitals have increased their number, size and scope. The unprecedented growth of governmental hospitals may not be the result of depression alone. It is, perhaps, an indication and a threat of a politically controlled system of medical and hospital practice. During the past decade the number of beds under government control increased 47 per cent and the average census in these hospitals increased 67 per cent. In contrast, the number of hospital beds in nongovernmental hospitals increased 17 per cent during this period and the average census increased only 3 per cent.

A program of subsidization of approved existing voluntary hospitals on a per capita per diem basis — a plan similar to the one in effect in Pennsylvania — would be more sensible and more economical than the duplication of existing facilities. Furthermore, government controlled hospital service may start out as the highest form of altruism but before long it may become politicalized hospital service. As long as the present elective party system prevails there will be the inevitable spoils and patronage.[1]

[1]Read at the convention of the American Hospital Association, Philadelphia, September, 1934.

Unusual Features Incorporated in Hospital Ambulances

Hot and cold running water, full-sized couches for two patients and interior heating and cooling facilities are among the special appointments of the three new ambulances placed in service recently by Knickerbocker Hospital, New York City. A constant supply of hot water at a temperature of approximately 180° F. is made available through the use of a thermo-syphon system which derives its heat from a copper coil heating unit wound around the exhaust pipe.

A feature of the ambulances is the spaciousness of their interiors. Each ambulance is 102 inches long by 53½ inches wide. A large basin with hot and cold water faucets and a liquid soap tap are built into the forward end of the patient's compartment. Surrounding these are a series of walnut cabinets extending across the entire width of the car for storage of extra medical supplies. In addition to the conventional rear door, the patient's compartment is equipped with two other large doors, one on each side. The patient's couch is pivoted horizontally at the forward end and can be shifted in either direction, thereby allowing the surgeon to work from whichever side is more convenient.

Spaciousness of the interiors is a feature of the new ambulances placed in service recently by Knickerbocker Hospital, New York City. This view shows the large wash basin with hot and cold running water and the storage cabinets.

Someone Has Asked—

May Insurance Companies Demand Laboratory Reports Before Paying Compensation Bills?

A hospital superintendent states that he has had trouble in collecting payment for the care of compensation cases because a report of the laboratory examinations performed had not been previously filed or that it had been adjudged by the company as unsatisfactory. He asks for an opinion as to the fairness of this requirement.

Hospital executives everywhere experience no little trouble in collecting from insurance carriers for the treatment of compensation cases. A demand for laboratory reports, however, is unusual. It is difficult to understand the reason for such a stipulation since no uncertainty can rightfully exist as to the fact that treatment was given by the institution. The method by which the diagnosis was reached can be of no concern to the insurance company. It would be just as reasonable for the carrier to refuse payment unless the company's physician concurred in the study methods employed or in the type of instruments used in rendering surgical care.

If the company suspects the presence of a positive Wassermann, preexisting nephritis or long standing heart disease as underlying the accident or as delaying recovery, it should insist upon a more rigid physical examination of those whom it insures before they are employed. Such a request by an insurance company would appear to be evidence of bad faith or else a desire to evade just payment for the patient's care. Of course, the hospital should cooperate with insurance companies but it should not permit itself to be exploited or imposed upon.

How Can a Hospital Council Be Organized?

The executive of a hospital of 100 beds in a community where within a radius of fifty miles are a number of towns and cities, each containing a hospital, asks the foregoing question.

The hospital field can present a stronger front in financial and public matters if it is organized. Of greatest importance is the fact that a council of executives and trustees can accomplish much good for the community.

A meeting may be called of the superintendents and of one or more representatives of the boards of trustees of each institution. The nature and necessity for such a council can then be discussed. A decision should be reached as to whether the public is to be represented on the managing board of this body or whether only executives and trustees are to be included.

The scope of the work to be performed may then be decided upon. Such matters as standardization of fees, fixing of zones of service, regulation of methods of collection, avoidance of imposition upon the hospital by unscrupulous persons, and adoption of a routine in many matters that affect hospitals generally will be presented for discussion.

It is probably better for a hospital council to have represented thereon, superintendents, lay members of hospital boards, and one or more carefully selected lay members of the community. Representatives of medical, dental, nursing and public health organizations are also usually considered desirable. A board of directors may be selected and if the membership is sufficiently large an executive committee should be elected.

The success of such an organization will depend upon the presence of a leader who will guide it through the early difficulties that are sure to arise. Better cooperation among hospitals will almost certainly be followed by a clearer understanding of hospitals by the community.

Who Should Treat Gynecological Cases?

This is a practical query. A friendly feud often exists between the surgical and the gynecological staffs in regard to what really constitutes gynecology and what constitutes general surgery.

In some hospitals gynecology is not recognized as a specialty and surgeons perform all pelvic operations. It is contended that since the brim of the pelvis is usually set as the geographical boundary separating the operative fields of these two classes of surgeons, there is in reality no need for a gynecologist on the hospital staff. The latter, however, believes that the surgery of the female generative organs requires a peculiar training and hence should not be allotted to the general surgeon.

In some institutions where both types of physicians are found on the staff the dispensary is conducted by the gynecologist but the surgeon shares equally in the work referred to the surgical ward by this clinic. This type of organization is believed to be wrong and in most hospitals of size it is felt that there is a real place for the gynecologist both in conducting the out-patient clinic and in surgically treating patients of this type.

The hospital administration should firmly face the situation as to what arrangement is best for the patient. If a gynecological staff exists it should provide that all diseases usually assigned to this group be handled by it. Certainly, it is neither courageous nor efficient to endeavor to evade a decision and to allow these patients to dwell in a surgical no-man's land.

Should Visitors Be Allowed in the Operating Room?

A superintendent in whose institution the surgeons invite their nonmedical friends and patients to view operations asks this question. The surgical staff contends that it is within its prerogatives to create its own gallery.

There is a type of surgeon who apparently loves to bask in the horrified admiration of members of the laity. He learns that to create conversation concerning his scientific gifts is sometimes profitable. He descends to the level of tawdry showmanship to sell himself to his clientele. By so doing he cheapens the practice of surgery and does not reflect any credit upon his hospital.

A surgeon should have no authority to grant permission to anyone to visit any part of the hospital. The superintendent supported by the board of trustees should firmly interdict the practice of permitting morbidly curious laymen to occupy the galleries of the operating room at any time.

If you have any questions to ask, the Editor will be glad to discuss these in a forthcoming issue

An Important Task Lies With the Record Librarian

By ROBERT N. BROUGH
Superintendent, Norwalk General Hospital, Norwalk, Conn.

WITH but two or three exceptions, no position in the hospital demands more varied qualifications than does that of the record librarian.

The librarian should bring to her work specialized knowledge, integrity, intelligence, initiative, energy, common sense, adaptability. To her, rules are made to be enforced by tact, persuasion, flattery and discipline — the last only as a last resort. To her a schedule is important, for each day brings new duties and delay means inefficiency. These are some of the essential qualifications the record librarian should bring to her work. In addition she must have, first of all, loyalty and enthusiasm; second, accuracy and carefulness; third, mental alertness which is so necessary if the unusual or inaccurate record is to be noted and given the proper attention; fourth, an ability to understand or interpret figures; fifth, psychologic skill.

The record librarian is the watchdog of the hospital's records, just as the financial man is the watchdog of the treasury. No hospital in this country can today look the world in the face unless its records measure up to a reasonable standard. The handwriting is on the wall. We know what the future holds. It is our job to be ahead of the times by striving to meet the standards and the demands of five years hence. Much of our research is sadly hampered because records of even three or five years ago are not what they ought to be. Many a research worker in hospitals has had his ambition dashed to the ground, because upon undertaking a task that bore promise of extending even slightly our present knowledge, he was confronted with incomplete, unsatisfactory and unreliable clinical histories — unreliable because entries concerning essential facts were poorly recorded. The record librarian in the average hospital ought to see that such a condition does not exist. Clinical records go to the very heart of a hospital's existence, and there is ample opportunity week by week for the record librarian to help her institution in more ways than one by a spirit of loyalty and whole-hearted cooperation.

Possibly accuracy is so inherent in the work of the record librarian that any observations on this point are unnecessary. Yet, I dare say that a trained observer could within two or three hours detect several things that ought to be corrected in the records of many hospitals. Do you as a librarian carefully review your clinical records as they go through your hands to make sure that examination does not reveal errors, omissions or misstatements? Here is a real opportunity for the conscientious librarian. Are all procedures properly recorded? Have all laboratory reports been properly filed? Is there a missing consultation? Is the member of the body involved in a certain procedure or examination accurately recorded? Why not make the records scientifically correct? Few will challenge the statement that at least one out of five of the charts as they reach the record librarian requires correction, addition or alteration. Here the ability of the record librarian comes into full play and her stature may be judged by the results she secures. Here she needs to exercise all of her good qualities — tact, diplomacy, alertness, knowledge of human nature. Attending physicians, interns, nurses and out-patient department secretaries must frequently be handled along different lines, according to their individual

The hospital librarian needs many qualities if she is to fill the niche assigned her here by Mr. Brough. The ideal librarian, he says, will make certain that by study, training and experience she has fitted herself to handle with intelligence and alertness the vitally important material that passes through her hands. She will be a member of the National Association of Record Librarians

characteristics. It is the opportunity of the librarian so to act as to have necessary entries made promptly.

Mental alertness is as difficult to define as personality. With it we include a liking for daily routine. We must be careful in considering this characteristic to make allowances for variations in human nature. There comes to mind one librarian who went far beyond the confines of her job and made her hospital popular with a number of physicians in the community. This she did by greeting the stranger who had courtesy privileges, introducing him to nursing supervisors and extending special courtesies to him until he felt the fine spirit by which the institution was guided. The record system was made clear. In many other ways she made herself invaluable. All this she could do only by being always alert and watchful for opportunities to help the department and the hospital.

Figures Tell the Hospital's History

Some of us miss the mystery and lure of figures because we are too much in a hurry. We want to read and understand them as easily as we do words. That is impossible because figures are one of the best systems of shorthand we possess. Anyone who deals with figures must take time to understand them. The written page may be read in a minute or two but a page of figures requires five or ten times as much time.

In the average hospital the librarian or historian is properly charged with the responsibility of keeping what may be termed the vital statistics of the hospital — all figures relating to classification of patients, days of care, operations, deaths, births, and so on through a long list. If she views the task of assembling these as only a job to be got out of the way month by month as quickly as possible, she is missing the romance of her position. The true history of the hospital is written in figures. They reveal the effect of certain policies; they record the march of progress. No librarian gifted with the qualities mentioned here can assemble the statistics for any month or period without having her interest aroused. More than that, she makes certain that her figures tell the truth, the whole truth and nothing but the truth. From time to time she amplifies or rearranges her statistics so as to throw clearer light upon what has been done. Is the monthly report of the number of operations a satisfactory figure? Why not divide it between major and minor operations and then still further "break down" the statistics, so as to make a division between service and private cases? Why not show in comparative columns just what work each surgeon on the staff is doing?

The librarian should make sure that all vital statistics are maintained in proper form even though the task of compiling certain figures may be delegated to others. For instance, it is quite common for statistics relative to the out-patient department to be prepared by a clerk or secretary in that department. There is usually no valid objection to that procedure. If the history of the hospital is to be expressed in figures, is it not logical to conclude that the librarian is interested in any figures that relate to such an important department as the one mentioned, particularly as these statistics relate to health activities? With the financial figures the librarian has no particular concern but she ought to be interested in at least preserving all figures relating to the fundamental purpose of the hospital — the treatment of the patient. Also she should see that all figures with which she is concerned stand the test of common sense and critical inspection.

A further duty of the librarian is to see that a permanent record of the vital statistics is made in a book sufficiently large to last for several years. Too much reliance has been placed upon pamphlet copies of annual reports, which unfortunately have a habit of disappearing after a few years. A book of this nature is just as vital to efficiency as the general ledger or cash book.

Better Obstetrical Statistics Are Needed

The American College of Surgeons has made some important recommendations concerning the value of statistics to be gathered from clinical records. These relate to a method of statistically estimating the efficiency of the clinical work of the hospital and the staff. Perhaps we are looking ahead somewhat when we suggest that the average hospital should endeavor to keep figures of this kind. Why should we not keep statistics showing the mortality percentage of every important disease treated in the hospital, of every important type of operation and of the various surgeons associated with the staff?

Many hospitals are weak in their obstetrical statistics. Increasing attention is being given to the quality of obstetrical work done and it is a safe prophecy that during the next few years additional statistics will be required of hospitals concerning their obstetrical results. Some institutions are now maintaining an obstetrical record book in which all maternity cases are analyzed in columns. From it at the end of each month and each year it is possible at a glance to answer almost any question concerning obstetrical procedures and results. The value of such a record has been amply proved.[1]

[1]Synopsis of an address read at the meeting of the Connecticut Hospital Historians' Association.

An Ideal Operating Suite

By HAROLD L. FOSS, M.D. and EDWARD F. STEVENS, F.A.I.A.

Surgeon-in-Chief, Geisinger Memorial Hospital, Danville, Pa., and Architect, Stevens, Curtin and Mason, Boston, Respectively

NEVER in the history of our country has there been a period of hospital expansion equal to that which has taken place during the ten years preceding the depression.

During that time some of our finest institutions were created and while, due to lack of good judgment, we are now finding that in many instances we overbuilt, we have nevertheless as a result of our unrestrained optimism and enthusiasm some extraordinarily fine examples of hospital design and construction. It is, however, a noteworthy fact that in more than one case where millions of dollars were lavished, where the design was adequate and up-to-date and where the general effect was pleasing to the eye, in certain details the planning was executed with little scientific knowledge of the needs of special departments. As a consequence such architectural incongruities resulted that members of the organization, especially of the medical staff, were handicapped because of the lack of a comprehensive architectural understanding of the needs of their departments.

The operating suite will serve as an illustration. In some of our finest hospitals, perfect in nearly every other detail, there are operating departments so far from being well conceived that they are thoroughly inadequate in respect to arrangements and equipment.

Surgeons Take Little Interest

In most instances these defects have largely been the result of lack of interest on the part of the surgeons themselves. This dearth of enthusiasm and cooperation on the part of those members of the staff destined to use the department, together with a want of surgical and technical knowledge on the part of the architect, has resulted in some strikingly bad examples of operating room design.

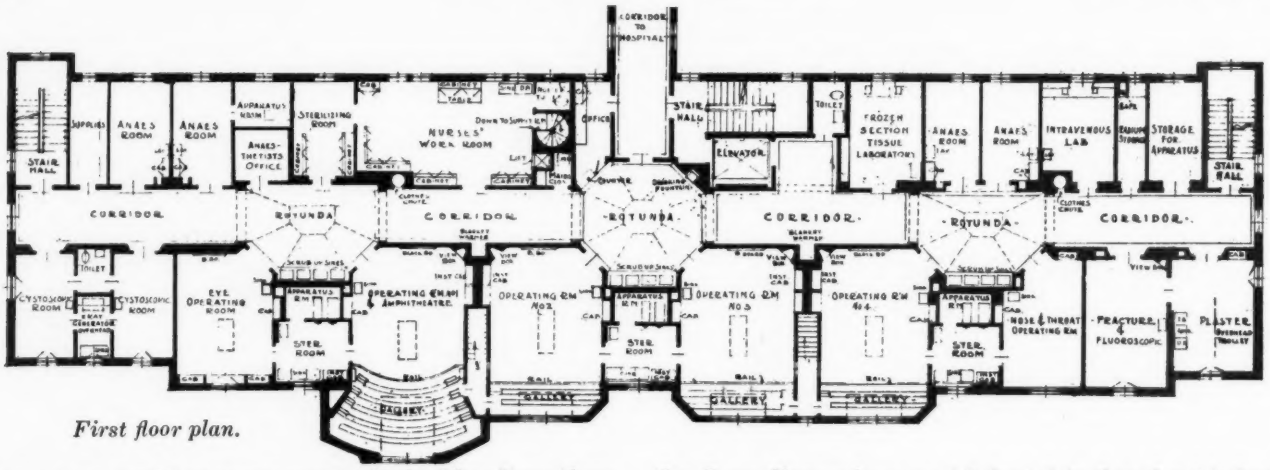
As an example, we have in mind the operating suite in one of our newest institutions, an institution affiliated with one of the country's leading medical schools, in which there is no laboratory connected with the operating suite, making it necessary for tissues from the operating rooms to be carried to another building before a quick histological diagnosis can be furnished. In another large and costly hospital designed within the past two years, visitors, instead of having an adequate view of the table, get little more than a glimpse of the back of the operator or of that of his assistant. Other recent examples of poor planning involve inadequate floor space; badly arranged lighting; omission of important rooms regarded as essential features of rapid surgical advancements; wrong selection of flooring and wall material; poorly designed systems of ventilation; absence of air conditioning; imperfectly installed plumbing and steam fittings; unfortunate color schemes, and similar inexcusable blunders.

A Composite Plan Is Evolved

With one of the authors (E. F. S.) hospital architecture has been a life work; while with the other (H. L. F.) it has been in the nature of a hobby in connection with his professional work as a surgeon. Within the past few years in the institution with which the latter is associated, he has been called upon to plan several new operating room suites. In view of their experience The MODERN HOSPITAL has asked the authors to pool their ideas of a surgical department and to set them forth in the form of drawings with an accompanying discussion. We are, therefore, describing in this paper an ideal operating suite for a 250-bed, nonteaching hospital—such an institution as might be needed in any community of moderate size and one in which the major portion of the hospital work of the city would be cared for.

With this purpose in mind, the authors have for several months exchanged sketches, altering them and redrawing them many times until a final plan emerged. A copy of these drawings was reviewed by the staff of Geisinger Memorial Hospital, and a final set of drawings was sent to six leading American surgeons for their criticism.

Of course, irrespective of how carefully plans may be prepared, they may always be greatly improved. Probably many readers will find points to criticize in the drawings we hereby submit but it should be realized that they are only tentative at best. They do, however, approximate our ideas of a perfect operating suite. It is possible that a year



First floor plan.

hence we could suggest many desirable alterations in the drawings; yet they represent our present ideas of a design which while it may seem Utopian at the same time does not represent an extravagant expenditure. If certain readers consider our plans impracticable, we must remind them that we were asked to prepare an "ideal plan" and that while the general scheme could be considerably simplified and still prove adequate, it is our feeling that the drawings could not be materially modified without seriously impairing the original purpose.

With this preface, we turn to the drawings themselves, setting forth our reasons for the general plan. In the first place, we feel that the operating suite in a general hospital should be in a separate wing. While not absolutely necessary, such an arrangement provides light and ventilation on all four sides, thus keeping this important section of the institution more or less isolated, divorcing it from the general confusion and noise of the rest of the hospital and possibly assuring greater cleanliness than would be possible were it an integral part of the main building.

The Department Is on Two Floors

To obviate the necessity for spreading the department over too great an area two floors are required — the operating rooms, anesthetizing rooms and allied departments being on one floor and such accessory rooms as laboratories, record rooms and locker rooms on the floor immediately above. One might argue that the order of these floors should be reversed, but the sequence we suggest permits the working out of a plan calling for a mezzanine gallery in all operating rooms access to which rooms would be from the floor above. By this arrangement students and visitors would have ready entrance to all operating rooms without traversing the operating floor proper.

In a hospital of 250 beds three main operating rooms would seem to be sufficient. In arriving at what we consider an ideal size we have specified the floor dimensions as 16 feet 6 inches by 19 feet 6 inches. Two rooms would be arranged as twins in which a surgeon with a relatively large operating list could work rapidly by alternating between the two rooms; a third operating room would be available for operators with shorter lists. Besides these three, a fourth room is provided for use on especially busy mornings. Such a room could also be used on the occasion of postgraduate assemblies, clinical conferences and clinical demonstrations, since it is provided with a small amphitheatre capable of seating about sixty visitors. Although the institution is not supposed to be connected with a university or medical school, the great importance of postgraduate teaching — something which has been especially stressed in the past few years — together with the availability of clinical material in the modern hospital, in our opinion makes the inclusion of such an assembly room essential.

All operating rooms are well lighted by large skylights. Although daylight is not absolutely necessary, artificial lighting often proving adequate, many surgeons insist, and rightfully so, on ample skylights. A smaller room for nose and throat work is provided, but without a skylight, because most of the operating in this department is performed under artificial light.

A fracture room is available in which open and closed fracture reductions can be carried out with the aid, if necessary, of the fluoroscope. Adjacent to the fracture room is a plaster room for the dressing of orthopedic and fracture cases.

All instrument and utensil sterilizers are of the recessed autoclave type, although in each room a boiler sterilizer is located to take care of instruments which have been dropped during the course of the operation and which may be required immediately. Instrument cabinets are placed in the sterilizing rooms. Such an arrangement is a great saver of steps and it gives ample storage space in which to place instruments after cleaning, from which they can be quickly removed for sterilization when

selected for the individual operation. An alternative arrangement would include a central instrument room.

Water sterilizers are installed on the floor above in a separate room capable of being adequately ventilated and from which hot and cold sterile water can be carried through block tin-lined pipes to the operating rooms on the floor below. It is an arrangement we have tried thoroughly, and while there are arguments against the plan, yet through years of experience we have found the set-up most satisfactory. Innumerable bacteriologic tests conducted for many years in a hospital in which one of the authors (H. L. F.) works have always resulted in sterile cultures. Locating water sterilizers according to this plan completely eliminates the noise, heat, humidity and cumbersomeness of large water sterilizing rooms, placed adjacent to operating rooms; furthermore, such a plan furnishes sterile water under pressure for all operating rooms.

Each operating room has a built-in x-ray view box and a small ground glass "blackboard" placed in the wall for the making of drawings and sketches. All rooms have neatly arranged, built-in cabinets of ample size finished with plate glass doors for special instruments, ligature material and other supplies. All rooms are equipped with vacuum devices for the removal of secretions.

A visitors' gallery to which there is access from the floor above extends across the north end of each operating room. Such a scheme keeps visitors and those not adequately gowned from traversing the main operating rooms, at the same time furnishing them ready access to the operating rooms as well as an excellent view of the operative work being performed.

Twelve scrub-up sinks are grouped in the three rotundas, all equipped with knee valves which, we feel, are far better than any type of foot or elbow valve. Foot valves are dirt catchers; elbow valves may cause a serious break in aseptic technique.

Two cystoscopic rooms are situated in the operating suite, since in this part of the hospital the most aseptic technique can be carried out. The rooms may be used for transurethral and other forms of cystoscopic surgery and if purely diagnostic procedures are being carried out, such as the making of pyelograms and urograms, an x-ray transformer is set up between the two rooms with current leads to both tables.

Anesthetizing rooms, adequate in number, are placed in as close proximity to the operating rooms as is feasible. All rooms have cabinets for the anesthetist's equipment, a sink for the washing of tubing, masks and other material.

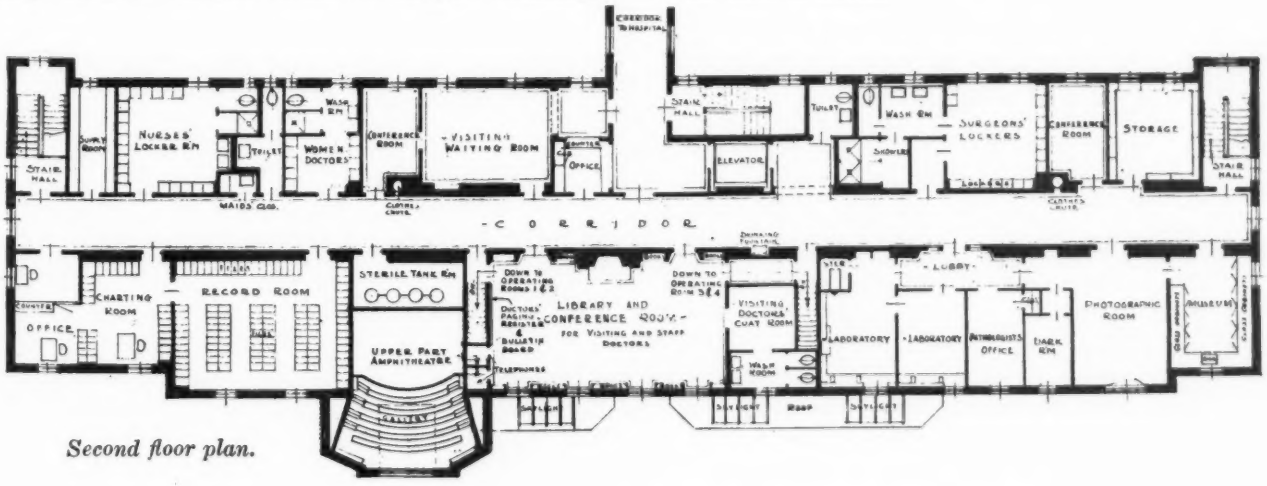
Terrazzo Recommended for Floors

All floors of the operating suite are to be set in terrazzo or ceramic tile, preferably the former, those in the anesthetizing and operating rooms being provided with a 4-inch brass mosaic, electrically grounded, to take care of all static charges especially during the use of nitrous oxide, oxygen-ether mixtures, ethylene and other explosive gases. All electric switches are of the nonsparking mercury type. All door and window frames are of steel and the entire construction is fireproof.

There is a large room for the preparation of supplies which is connected by means of a dumbwaiter and by a circular staircase with a stockroom in the basement where gauze, cotton and the innumerable supplies used in the operation of a modern surgical unit are stored. In connection with this room there will be found a large sterilizing room with generous built-in utensil sterilizers. At each end of the suite a clothes chute of the porcelain aluminum lined type capable of being thoroughly cleansed is provided. A passenger elevator large enough for full-sized wheel stretchers is located in the central portion of the suite, with a second and smaller elevator for the use of the staff.[1]

While it is understood that adequate laboratory

[1]Not shown on drawing.



Second floor plan.

facilities are to be had in the general pathologic department in the hospital proper, there is, in addition to the surgical laboratory on the second floor and adjacent to the operating rooms, a small fresh tissue laboratory equipped with a freezing microtone and microscope for the immediate making of frozen sections.

It is everyone's conviction, we believe, that the preparation of intravenous solutions should be carried out with the greatest care and in the most aseptic surroundings. It is therefore felt there is no place more suitable than the operating suite for the establishment of the intravenous laboratory. Surely it has no place in the general pathologic laboratory where, curiously enough, it is found in many of our best institutions. We therefore place it in the operating room under the supervision of the head operating room nurse. In such a laboratory in a moderate sized hospital of the type we visualize and running an active general surgical service, probably 100 to 125 liters of solution would be prepared each week.

While radium may be used in the other departments of the institution, the best place for its application is in that section of the hospital where the most aseptic conditions are maintained, which of course is the operating suite. Preparation is therefore made for radium storage in a built-in safe provided with a combination lock.

In many of the recently planned operating suites no allowance is made for maids' closets, rooms for the storage of accessory apparatus, fracture equipment, wheel stretchers, diathermy and fulguration apparatus. In this suite the space allotted to these details is, we feel, none too great.

Arrangements for Visitors

On the second floor and immediately above the operating rooms will be found an assembly room for visitors and staff members. This room, which contains the surgical library, would be used for meetings of the surgical staff and for visitors, particularly during the holding of conferences and postgraduate assemblies. A visitors' coat room, with wash room and lavatory adjacent, has been provided with an ample locker room for gowns. By stepping down one short flight to the mezzanine floor visitors have access to the galleries provided in each operating room.

While we visualize there would be a main record room in the hospital, there should be in addition a special room for the cross indexing of cases by operation and a charting room in which an analysis of operations could be carried out by trained clerks. Ample space is therefore added for this purpose. On the same floor there is space for lockers for all the nurses engaged in the operating department.

On this floor is a small waiting room for lay visitors. To this room relatives and friends of patients who have been operated upon may be brought for conference with the surgeon immediately following the operation. Such a room may seem unnecessary, but in one of the new hospitals we have in mind it is a feature that is proving indispensable. It furnishes the surgeon an opportunity for meeting the relatives promptly following the completion of the operation so that he may reassure them and allay their fears or, if the necessity arises, acquaint them with the serious condition of the patient. Ample locker rooms, dressing rooms, shower baths and toilets are provided for attending surgeons.

Liberal Space Allotted to Laboratory

In our ideal hospital provision is made for a surgical pathologic laboratory apart from the general pathologic laboratory in the main building. This, too, may be thought unnecessary, but we insist that at least there should be a fresh tissue laboratory for the making of immediate frozen sections. In our ideal plans, however, in addition to the frozen section laboratory, we include a general surgical laboratory on the floor above, an office for the pathologist, as well as a photographic room and dark room for the making of lantern slides, of photomicrographs and photographs of gross specimens. We believe firmly in the importance of allotting liberal space to the department of surgical pathology, in addition to that provided for the general clinical laboratories. Near by is a small museum in which interesting surgical specimens can be preserved. This feature may be dispensed with if a larger museum is provided in the clinical laboratory in the main building.

Walls and ceilings would be insulated against change in outside temperature, and the entire working portion of this unit — operating rooms, sterilizing rooms, nurses' workrooms and assembly rooms — would be thoroughly ventilated and air conditioned, the air being washed and forced into the rooms through ducts from the basement. The same unit would be used to cool the air in summer and to heat it in the winter and would have needed devices for humidifying or dehumidifying.

Operating tables would be illuminated by some reflected type of light. Sanitary coves and bases in terrazzo would be specified. Operating rooms would have a flush vitrified dado extending five feet from the floor, the sterilizing rooms being tiled on walls and ceilings, the remainder of the walls being of hard plaster and enameled. The color of the tile in all the operating rooms would be neutral slate gray, the walls above being done in old ivory. Quite decidedly we would not specify the fantastic shades

being used in so many newer operating rooms.

Corridor walls would be in hard plaster and enamel and preferably would be provided with a tile five-foot dado or wainscoting. Ceilings of main corridors on both floors would be sound deadened.

Illumination of all rooms other than the operating rooms would be of the semi-indirect block type.

In the design of some of the sterilizing rooms it is proposed to call for installation of a double-ended instrument and utensil autoclave, thus permitting equipment to be placed in the sterilizer from the sterilizing room and after sterilization removed through the other opening directly within the operating room. Such a device is new but it is one being used in some of the more recent hospitals; it is a plan possessing definite advantages. The drawings do not show this arrangement but on revision the idea would certainly be carried out. Water sterilizers could of course be placed in the main sterilizing rooms on the operating room floor providing the arrangement shown in the drawings is not approved of. If installed in connection with the dressing instrument sterilizers they could be reset.

Naturally, the exterior of the building would be made to harmonize with the main hospital group and the general design, construction and finish made to conform with the ideas of the individual architect. The whole scheme is subject to many modifications and changes but the plan as herein described represents our idea of a fairly ideal operating suite for a general hospital of 200 to 250 beds.

Pooling Effort Brings Best Results

By R. FRAZER ARMSTRONG
Superintendent, Kingston General Hospital, Kingston, Ont.

IN THE hospital organization it seems essential that recognition be given to two broad divisions of administrative responsibility. The first division I would term the policy division, the second, the executive division.

In determining policies there should be available the vision, brains and experience of a broad-minded and experienced group. This group should include in its membership those capable of interpreting the present and future community hospital requirements, and capable also of determining progressive and prudent policies after drawing fully upon the knowledge and experience of the executives in the organization.

In the executive or administrative divisions the work should be headed by an individual with hospital training who is well grounded in the fundamentals of distributing executive responsibility, and who at the same time has the administrative knowledge and the personality that will enable him to win the respect of his assistants and the good will of his board and of the community.

To obtain the desired hospital atmosphere there must be on the part of the policy board and on the part of the superintendent full and sympathetic recognition of their respective responsibilities. At the same time the board as a group and the superintendent as a central executive should be cooperative enough to pool their efforts, knowledge and abilities in order to develop an efficient, vigorous and harmonious organization. As far as either the policy board or the superintendent falls short of these ideals so far will the hospital fall short in extending the highest type of service.

In the set-up of the policy board, in addition to capability, due consideration should be given both to continuity of policy and new ideas and contacts. The board should be large enough to obtain the necessary group opinion, but small enough to give a single front in the decision of all policies.

I am definitely of the opinion that standing committees for separate consideration of policy, except in a consultative or study capacity, create a condition that does not tend toward harmony or efficiency. All problems should be centralized through the policy board. Other committees may be desirable at times but only for gathering information.

In addition to its responsibility for determining policies, the board of course is responsible for choosing and supporting a qualified superintendent. Having chosen the superintendent the board should protect his prestige by routing its policies through him for execution.

The superintendent on his part should have that knowledge and talent for organization which lend encouragement to the development of individuality, initiative and progressiveness on the part of his assistants. While the board should be big enough to choose the right superintendent, so the superintendent should be able to choose capable assistants. In addition to allocating responsibility, he should be big enough to give credit to cooperative workers.

Starting a Group Insurance Plan in a 150-Bed Hospital

By ALBERT G. HAHN, F.A.C.H.A.
Deaconess Hospital, Evansville, Ind.

GROUP life insurance is becoming more popular with the public in general because the new social order encourages everyone to cooperate. In group insurance the young share the burden with the aged and the strong share the burden with the weak since group insurance does not entail a physical examination.

You ask, "What are the advantages of Group Insurance?" Permit me to state them briefly in my own words and not in the language of insurance agents.

Group life insurance is offered to a group of employees providing the majority of the group approve. This type of insurance on the average costs just about one-fourth what ordinary life insurance costs. By ordinary life I mean straight life of a maximum protection for a minimum premium annually until death. The premium rate is based on the average age of the employees subscribing. At the Deaconess Hospital the employee pays sixty cents a month per thousand dollars or $7.20 a year. This rate as compared with the rate in old line companies will be found to be small.

Hospital Pays Part of the Premium

The reason an insurance company can offer so much protection is because a large amount of insurance is sold at one time and in Indiana the employer must assume a portion of the premium. For instance, in addition to the sixty cents each month per thousand dollars paid by the employee the hospital pays twenty-three cents each month per thousand. On the basis of 100 employees each with $1000 of insurance it costs the hospital only $23 a month. The result is better morale, and satisfied employees are worth ten times this amount to the hospital. The employee's payment is deducted from the pay on the first of each month.

The following letter is typical of those sent to the parents of our nurses, to employees and to other interested persons:

Dear Member of the Deaconess Family:

And it is on just that basis that we are pleased to make the following statement, which concerns the security of us all.

Our board of trustees, realizing the loyalty of our employees and being concerned in their individual welfares, have decided to institute a plan of group life insurance, thereby assuming their share of the cost and permitting us all to have protection on a basis that is impossible to secure otherwise.

Can you imagine having a policy for as little as sixty cents per month, that will in event of your death from any cause, at any time, in any place, provide a sum of $1000?

In order to make this possible, the hospital is assuming the balance required, namely 23 cents per month, making a total of eighty-three cents per month on each $1000 contract. You no doubt realize also that this is available to all of us, irrespective of age or physical condition.

Should you leave the employ of the hospital at any time, you may convert this policy to any one of the company's standard policies with the exception of term insurance, without medical examination, at rates at your age at the time of change. Thousands of people want insurance but can't have it, on account of their physical condition.

We have arranged to handle the detail of premium payments through our office, by monthly pay roll deduction, thereby relieving you of that trouble.

Knowing the merits of insurance, realizing the low cost, we highly recommend it for your consideration, and assure you that the board is pleased to carry its share, hoping that each and everyone will be included. A card of application is enclosed which we ask that you fill in and turn in to the office. Should there be further questions you would like to ask, we wish to advise that representatives of the Sun Life Assurance Co. will be here to answer them for you. Folks, this is an opportunity. Let's each and everyone take advantage of it.

Very truly yours,

We were amazed to find the parents of our student nurses were extremely interested and wanted this coverage for their daughters.

Rates in other hospitals may be less, as we had some employees who were in the class of sixty years of age. These were employees who helped us build our institution and we will not discharge them now when they have reached the sunset of life.

After the second year we may be entitled to a dividend. We are not depending upon that but consider the twenty-three dollars well spent. The hospital will receive the dividend and if there is an increase in the premium the hospital will absorb it. We did not institute the plan to make money but to be of service to our personnel. Each employee was interviewed personally and given the privilege of accepting or rejecting the plan.

When applying for the group insurance, we paid the Sun Life Assurance Company of Canada $100 to cover all personnel and then when we interviewed the employees we told them they were already covered until they said "No." This was just a matter of good sales psychology.

Planning a Supervisory Program

By M. MacLACHLAN
Supervising Instructor, Department of Nursing, Presbyterian Hospital, Chicago

PLANNING is a fundamental principle of supervision. These plans show that the supervisor has thought through some of the urgent problems in her department and is making an attempt to solve them. They also tend to stimulate definite professional activity and improve the type of supervision. Often a supervisor is so submerged in details that it seems impossible for her to plan a program that she will be able to carry out, or in a good many cases she is a mere roundsman traveling from ward to ward criticizing what she does not like and forgetting that supervision is a matter of constructive, cooperative leadership.

There are two essentials in planning a supervisory program, first, to determine the needs of the department and the definite attainable objectives; second, to make a detailed outline of the means and devices by which these objectives may be attained.

The objectives chosen will need to be fairly broad. They may not be the ones most needed in all the units of the department but the general welfare and progress will probably be more advanced than if the supervisor chose the special needs of each unit rather than the greater need of the whole department. These special needs should provide objectives for the respective head nurses in the units. The time available and the time necessary for working out the objectives must also be considered.

The Entire Staff Should Participate

The means by which the objectives are to be carried out will depend to a large extent on the nature of the objectives and the time available to spend on them. The supervisor must remember that she is primarily a teacher and leader and that she can accomplish little alone and the devices she uses must provide for participation by all members of her staff. Often the program can serve as a staff education program as well as a supervisory one by making use of such devices as head nurses' meetings, visits to other institutions by staff members and demonstrations, and by providing literature on the subjects in question.

The following is an example of a supervisory program that pretty well illustrates the principles stated above. The supervisor stated her objective as follows: to make better use of teaching opportunities and clinical material on the wards in helping students integrate theory and practice and to improve the nursing done by the graduate staff. She set aside the time from January first to July first for this project. In studying the needs of the department she found that the presentation of the morning report as a teaching opportunity and the method of assigning cases to students were not being used to the best advantage and that through concentrating on them she would accomplish her objective.

Two Devices Were Used

The first device used was the monthly meeting of head nurses, supervisors and instructors. This meeting consisted of a demonstration of a morning report conducted by a head nurse with a group of students. The demonstration lasted about twenty minutes and was followed by a discussion of such problems as the care of the patients during the report should the night nurse participate, and what contributions should be expected by the graduate staff.

Secondly, the supervisor participated in morning reports herself. These were planned and scheduled with the head nurses and were followed by conferences. These conferences were especially helpful in making possible a better correlation of the work done in the classroom and on the wards, in that the supervisor who taught the classes and attended the lectures assisted the head nurses with planning the subject matter for the morning conferences and provided references on the work taken up in the classes. The head nurses in turn pointed out where the students were weak and what things needed to be drilled in the classroom. Individual problems of students and graduates were also discussed and plans made for helping them. These conferences were not usually held directly after the report because of the routine work requiring the attention of the head nurse at that time of the morning.

The same devices were used in emphasizing the case study method of assignment to obtain the maximum experience the ward afforded for the students. At a monthly meeting there was a discussion of the general educational principles in-

volved, the technique of making assignments by this method and the use of the graduate staff in such a plan. The supervisor assisted the head nurses in making their assignments and arranged for each student to have as far as possible all the experience offered by the ward. She also held conferences with students on the wards.

Although a supervisor has worked out a plan in some detail she must consider it as a flexible one. When she begins to work it out she may find better ways and means to accomplish her ends. She may not have allowed herself time enough to get the results she anticipated or she may find that she is taking more time than is necessary.

Much of the interest of carrying out a supervisory program is lost unless some method of measuring results is used. In carrying out an educational program of the type described the daily teaching on the wards and inspection of students' work will show the supervisor the results of her work. The students' reports made out by the head nurses should also be watched for improvements made and weaknesses still existing which may provide practical objectives for any later plans.

Hospitals Must Change With the Times

By R. W. NELSON
Manager, Portland Sanitarium and Hospital, Portland, Ore.

THE primary task of the hospital is to provide adequate, up-to-date facilities, and well trained personnel, to care for the sick of its community. This fact is self-evident.

Experience, I believe, has proved that our voluntary hospital system is the best plan that has yet been produced. But the future of the voluntary hospitals is less secure at present than it has been for a long time. Present economic and political conditions must be carefully studied by the hospital administrator today.

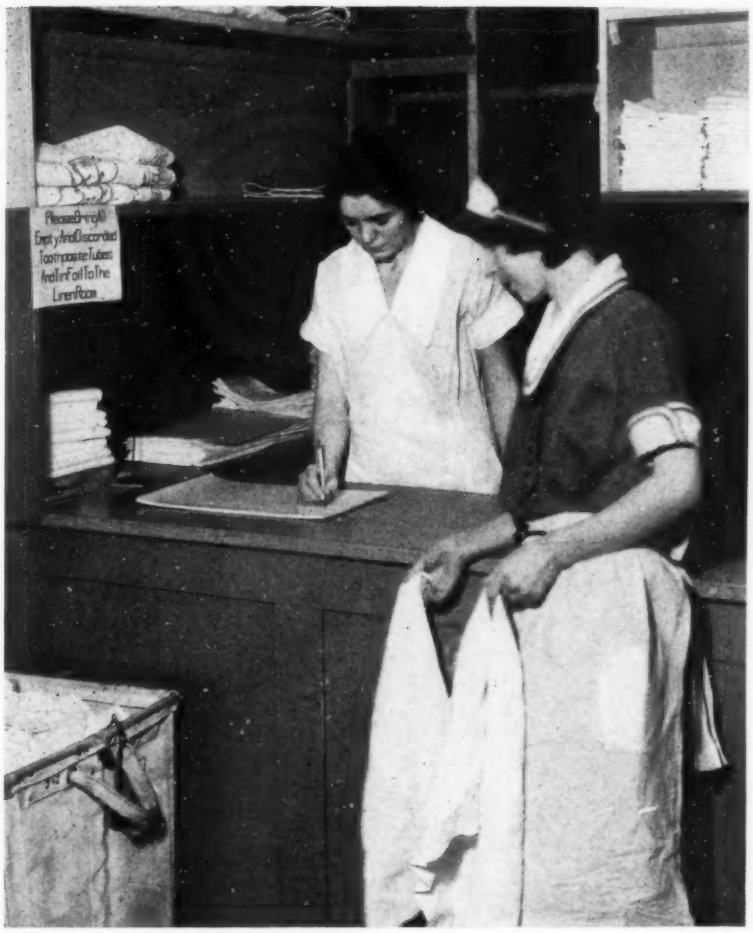
It is my belief that at the present time the hospital can render no greater service to the citizens of its community than to devote its thought and its resources to long distance planning to meet the situation that is developing and will develop under changed social conditions. Let us recognize that a changed order is going to prevail, and let us so plot our course that we shall be in position to serve the health needs of our respective communities.

I hold that the private patient under the care of the physician in private practice is an indispensable relationship to successful, efficient medical and hospital practice. But medical science is going forward and will go forward. The hospital must keep step with medical progress. It has kept step, with resultant increasing costs which have put its services beyond the financial reach of the large low income class. Thus the hospital and the medical profession have suffered from lack of patronage, while the public has suffered for lack of needed medical services.

There is also much misapprehension on the part of the public regarding the hospital. Despite the progress that has been made, there is still a large share of the population that actually fears the hospital, on both the physical and the financial side.

If as voluntary hospitals we are to fulfill our destiny we must throw overboard our prejudices and preconceived ideas and get right down to the foundation of the economic problem with which our citizens are confronted. One fact stands out. The large group of low income citizens cannot from their individual incomes pay what it costs to receive proper hospital and medical service. Some plan of social medicine is inevitable. We can resist it and eventually find ourselves submerged in socialistic and politically directed state medicine. Or we can lend our influence to shaping it and controlling it for the benefit both of ourselves and the public. The highest ideals of practice in our field demand that we follow the latter course. Our hospitals today can render no more effective service than by uniting in community and statewide councils and planning jointly to offer to the public all necessary facilities and services upon an equitable social insurance plan which will make it possible for the whole public to avail itself of the splendid facilities and services that exist. Health insurance is coming. It will be sponsored by the hospitals and the medical profession if we will it so. If not, it will be sponsored politically.

And with our long distance planning we can and must render another service. We must tell the public what we have to offer and what we are doing to put our hospitals within the reach of all classes. Here is a challenge that calls for the best we have. Our traditional attitude of aloofness must be abandoned. Yet we must not plunge into spectacular advertising. Concerted action by hospitals, putting on a high grade program of educational publicity must be our aim.



A Housekeeper Analyzes Her Manysided Job

By DORIS L. DUNGAN
Housekeeper, Jeanes Hospital,
Fox Chase, Philadelphia

THE organization of the housekeeping department centers around the selection of the housekeeper. This individual must have the general qualities that should characterize any executive—interest in her work, strong personality and a scientific trend of mind. She must be interested in her institution for no real service can be rendered unless department heads cooperate intelligently. She must be interested in her employees, not only because she is largely responsible for their health, happiness and general welfare but because she wins their loyalty by her friendliness and interest.

By her interest in her work she creates enthusiasm in herself and others. Strong personality in an executive creates confidence. This is dependent on sufficient training and education and also on health and nerve endurance. A scientific trend of mind will enable her to plan the work and to execute the plan.

In addition to these general qualities there are more specific ones a housekeeper should possess—a technical knowledge of the composition and characteristics of supplies and commodities used by her department; teaching ability; capacity for supervision and inspection; efficiency from the standpoint of economics, and ability to avoid being influenced by personalities. The ability to get on with people is important as the housekeeper is in contact with all grades of intelligence, from professional people to the below average workers in her department. Knowing how to analyze and handle people will enable her to place them in positions most suitable to their characteristics and will help her to judge the approach to each type that will get responses that promote harmony.

The first thing the housekeeper should do is to analyze her job. It will be of help to her to make first a chart of the institution showing the relation of the housekeeping department to other departments, then to make a chart of her own department showing each worker's relation to the head. This analysis will improve internal relationships, simplify selection of workers, establish standard practices for training and give a basis for the classification and grading of positions.

These are good outline points to follow in housekeeping analysis: a list of all pay roll jobs in the department; buying, repairs, replacements inspection and upkeep of equipment and supplies; a list

This article is one of the Hospital Organization Series, under the direction of Dr. Winford H. Smith.

SCHEDULE INDICATING HOW HOUSEKEEPING PROBLEMS HAVE BEEN WORKED OUT IN ONE EASTERN HOSPITAL

On duty 7:30 a.m. to 4:30 p.m. Breakfast 7 a.m.—Lunch 12-1 p.m.
Off duty Thursday p.m., alternate Sundays

DAILY 7:30 A.M.
- Bring requisition to linen room to be filled and place linen in nurses' linen closet
- Get ice for diet kitchen
- Sweep two sunparlors
- Clean service rooms
- Sweep nurse's office
- Sweep all rooms
- Sweep halls
- Empty trash cans morning and afternoon

MONDAY
- Polish all brass, door treads, plates and handles

TUESDAY
- High dusting — tops of diet kitchen cupboards, tops of all doors and lockers

MONTHLY WORK
- First week—All lights and radiators
- Second week—All windows
- Third week—All tile
- Fourth week—All doors

MISCELLANEOUS
- Responsible for cleaning of floors, windows, doors, lights and radiators in 8 private rooms and 8 wards. Cleaning of diet kitchen floor and windows, nurse's office, two service rooms, two sun parlors. Care of hoppers. Report rooms when vacant for special cleaning.

of the definite responsibilities of each employee.

Then it is well to make an analysis for each type of worker needed in the department. This information can be kept on reference cards and makes interviewing applicants much simpler. Give precise nature of operation, the pay for beginners and scale of advances, also opportunities for promotion and time required for the average good worker to perform the work. List any unattractive features about the job, such as whether it requires standing, sitting, stooping; whether it is wet, dusty, hot or cold. Under characteristics desired of the workman list physical requirements such as age, height, sex, length of arms and legs, size and sensitiveness of hands and fingers, cleanliness and part of body most used for that job. Note whether any special knowledge or experience is required; also note age limits and mental characteristics desired. There may be jobs in which certain physical defects would not be a handicap. A study of tools used on the job is important from the standpoint of mental characteristics. For instance, a higher type of individual is needed to handle electrical equipment than to push a broom.

Selection of employees may be made from written or personal applications, from employment agencies or by advertising. Since the job specification has been clearly defined the personal interview will serve to give and receive information. It will also establish a friendly relationship.

Employees are trained by instruction and supervision. Duties must be clearly defined. Both group and individual teaching will be necessary to give the worker a clear understanding of his work.

Supervision will give the housekeeper an opportunity to judge the worker on the job. She should check to be sure that definite instructions have been carried out and if criticism is necessary it should be constructive.

The number of personnel necessary will depend on the type and policies of the institution and also on the physical conveniences or inconveniences. The work must be carefully scheduled in order that it may be adequately covered at all times. A typical schedule should cover day to day work—number of rooms, time allowed for each room, routine; exceptional duties; heavy cleaning schedule; hours on duty.

Facilities for the housekeeping department should be taken into consideration when the hospital is built. An office, not a desk in a busy crowded linen room, should be provided. It means a saving on nerves and disposition if the housekeeper has a private office where she may interview or consult with employees, where departmental meetings may be held, where books and records may be kept.

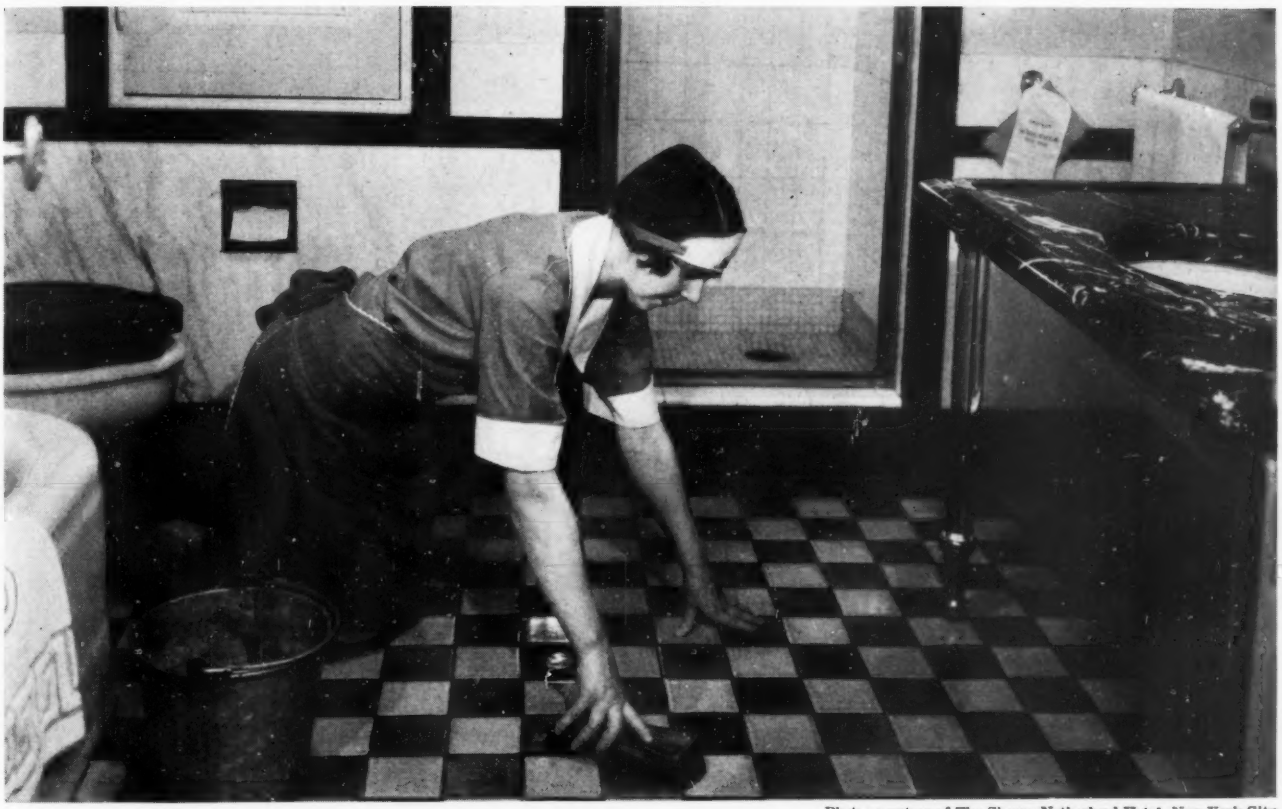
Linen rooms and sewing rooms are usually near together. They should also be near the elevators used for handling linen. Separate storerooms for new linen, which are kept locked, should be near

PORTER'S SCHEDULE FOR THE PRIVATE PATIENT BUILDING OF A LARGE METROPOLITAN HOSPITAL

On duty 7 a.m. to 5 p.m. with lunch hour. Breakfast 6:30 a.m.
Off duty Thursday p.m., alternate Sundays

DAILY 7 A.M.
- Put trash on dumb-waiter; clean flower room; flower compartments when required; doctors' toilets
- Vacuum rugs in waiting room and doctor's office; small rugs from rooms (average 35 to 40)
- Sweep porches; dust wheel chairs
- Clean nickel in doctors' room, waiting room, nurses' toilet and bathrooms
- Clean floors and equipment in hall bathrooms; bathtubs to be cleaned as often as necessary
- Empty scrap baskets and replenish soap and towels when necessary
- Empty garbage cans, scrub cans in basement; keep all trash cans empty
- Clean small compartments when necessary (30 on each floor)
- Wash out ice chests before they are filled; wash floor of refrigerator; keep drains clear
- Sweep halls during afternoon

MISCELLANEOUS
- Clean windows and vacuum rugs in patients' rooms when asked to do so
- Keep clean all windows, nickel, lights, bedroom doors, mirrors in waiting room and nurses' room, glass in all hall doors, including stair doors, and ledges; sweep litter and chair rooms
- Upon discharge of patients all rooms to be thoroughly cleaned; electrical fixtures checked
- Vacant rooms — Rugs to be vacuumed each week; nickel and windows cleaned when necessary; windows fastened, shades down, lights out
- Scoops must always be used in handling ice
- Eating and loitering in pantries strictly forbidden



Photos courtesy of The Sherry-Netherland Hotel, New York City.

Bathmaids need not look untidy even when scrubbing. The cap keeps the hair in place and the short sleeves give a neat appearance and also allow more freedom of movement.

the main linen room. Floor linen closets in hospitals are usually in charge of the floor nurse. If there is no central storeroom there should be a separate storage place for housekeeping supplies and equipment. Hopper closets should be roomy enough to contain cleaning articles necessary for that unit, also shelves and hooks. Sinks should be set far enough from the door to prevent splashing when pails are filled or emptied. Light and ventilation are often forgotten in sink and storage closets. Ventilation to the outside is especially desirable in hopper closets.

If employees do not live in, rest rooms must be provided where clothing can be changed. State laws vary as to toilet facilities but the architect will make the required allowance. Soap and towels should be provided, also showers for employees who live out. Meals are usually furnished, at least one hot meal in the middle of the day, as part of wages. A cheerful place to eat will pay dividends in more rested, contented workers.

Money invested in good tools reduces upkeep and ensures better work. Standard lists of equipment for 100-bed hospitals are available. One of the interesting trends is that less scrubbing and more polishing tools are being bought. Each employee should have his own tools for which he is held responsible.

Tools should be adapted to their use. For instance a long handled brush may be used as a dustpan and baseboard brush and will also reach moldings and tops of doors. Places that require stooping and stretching are often neglected because of the extra labor involved. Extra length in handles reduces fatigue and means more and better work. The energy used in holding a curved brush is far less than that required to grasp a straight-backed one. Detachable handles are an economy as one handle will outwear several brushes.

The life of cleaning equipment depends to a great extent on whether it is given proper care when it is not in use. Brooms and brushes should be hung up, kept clean and used only for the purpose for which they are intended.

Any equipment that lightens labor and reduces fatigue is good. Fatigue causes workers to drop things, to break furnishings and equipment, to fall more easily, to be easily irritated and more susceptible to illness. It is wise to buy labor saving equipment and hire people for shorter hours.

In buying supplies technical knowledge is necessary. Ordinary housekeeping supplies, besides furniture, linen and blankets, are soap — cake, liquid and powder — cleaning compounds — cake and powder — wax and polish, paper goods, brushes, brooms, mops and miscellaneous supplies.

It is wise to standardize on a few good tested supplies and stick to them for it is easier to teach untrained help exactly how to use one cleaning material for each variety of work than to expect them to use their intelligence with new and different compounds. Determine the type of soil or stain and the best means for its removal. There is an interesting table of abrasives graded according to hardness. Taking ten as a standard the lower the scale goes the softer the abrasive:

10	diamond	5	steel wool
9.5	carborundum	4	flourspar
9	emery	3.5	jewelers rouge
7	sand	3	chalk (whiting)
6–7	pumice or volcanic ash	2.5–3	copper tinsel
6–7	feldspar	2.5	china clay
6	glass	2.5	finger nail
5.5	steel knife	1	graphite

A cleanser that works by mechanical action is usually safer in untrained hands than one that works by chemical action. So much educational material is available that any housekeeper can acquire the necessary knowledge to test and judge supplies. The Consumers Research gives disinterested reports which can be had for a small subscription. One safe guide is the reputation and reliability of the firm from whom you are buying.

The housekeeper usually keeps her own pay roll. This covers name, title, hours or days of service, rate of pay, deductions if any and total amount to be paid. There should be a standard policy about advancing wages and about payment during absence due to sickness. There should also be definite payment rules about vacations, overtime, Sundays and holidays.

Records of all mechanical equipment should give the name of article, its number, date of purchase, price, from whom purchased and the date and cost when any repair or replacement has been made. This will often show that a cheaper machine costs so much for repairs that it would have cost the hospital less to have bought a higher priced one. This same record should provide for definite inspection periods of all housekeeping equipment.

Linen records vary according to the linen control system in use. Perpetual inventory cards provide a check on new linen and an aid to future buying. Standards for each floor linen closet will vary with the type of service in that department. The standard for each floor should be posted in that closet.

Besides the specifications made for hiring employees some personal information should be kept about those employed, such as name, home address, telephone, nearest relative, whom to notify in case of illness or accident, references and any personal remarks about the quality of work.

Reports of finished work are a source of pride to the worker and a method of comparison for the housekeeper. Records of all major cleaning should be dated.

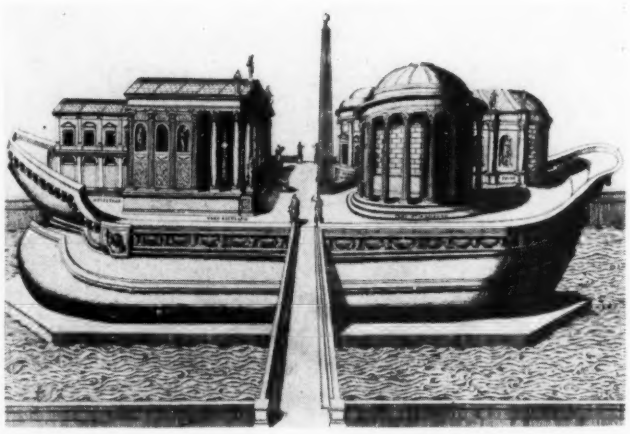
A good guide for the number of records necessary to be kept is to write down everything a new housekeeper would need to know if it were necessary for someone to assume the position unexpectedly. Records are the property of the institution. It is a part of the housekeeper's job to keep them but they must never be destroyed or removed. It should be the pride of every executive housekeeper to have her department so well organized that any other trained housekeeper could carry on without difficulty, or even so systematized that it could run smoothly under its own power in case of emergency.

Hospital History in Pictures

Our cover design this month is an architectural rendering of the Roman Temple of Æsculapius on an island in the Tiber. This was used as a hospital. Roman hospitals of the pre-Christian era were similar to those of Greece, the Romans having adopted the Greek custom of having public physicians, usually Greeks, paid from the public treasury.

In 292 B. C., so goes the mythical story, there was a pestilence in Rome, in the hope of curing which an embassy was sent to Epidaurus in Greece. The ambassadors brought back a sacred serpent, which when the ship arrived at the island in the Tiber left the ship and swam ashore there.

In commemoration of this a temple of Æsculapius was at once erected on the island, and the whole island was built up in the form of a ship. An obelisk to suggest a mast was set up on the island and temples were also built to Jupiter and Faunus. A little of the stone work is still left at the stern of the ship on the port side as it sailed up stream. Here are bas reliefs of the serpent and the head of the god.



The island is now the site of the Church of San Bartolomeo and a monument is on the site of the obelisk.

The restoration of the island shown in the accompanying picture was made in 1581. The reproduction is from an engraving said to be by Du Pérac.

Pledged But Not Paid

By PERRY ADDLEMAN
Chicago

IN REVIEWING the material results of a fund raising campaign, nothing should receive more attention than the terms and character of the pledges made. That seems obvious. Calculations of the true cost of the campaign, its net results and what procedure is warranted after the campaign — these and a dozen other important considerations are based upon an analytical examination of pledges. And these calculations are not difficult.

To exemplify some of the figures let us assume that a campaign has obtained pledges totaling $500,000 and that the total cost of the campaign was $25,000. Deducting the cost of the campaign we find that the so-called net result is $475,000. This is about as far as most persons go in calculating the cost and results of a campaign. But is this $475,000 net? No, it is not.

Experience indicates that these pledges will not be paid in full — that depreciation of the face value of the pledges because of nonpayment will amount to a considerable sum and will depend upon the duration of the pledges. If they are one-year pledges and high pressure solicitation methods have not been used, the depreciation should not be more than about 4 per cent, provided good collection methods are employed. Under similar circumstances two-year pledges will show 5 per cent depreciation, three-year pledges about 7 per cent. We will assume here that pledges run for three years and that consequently they will depreciate 7 per cent. Then we must deduct another $35,000. We now have $440,000 remaining.

Net Value of Pledges Is $382,000

Of course we must use good collection methods to obtain that amount. Collections will cost something and if we decide not to set aside a sum to defray collection costs we can be assured that the depreciation of these pledges, because of nonpayment, will be much higher than the 7 per cent we figured on. Let us set aside 4 per cent for collection. For the amount involved and duration of our pledges — three years — that is about the right amount. Then we must deduct $20,000 more. We can save the $20,000 if we want to, but we will probably lose two dollars for every one of it we save. So we decide to set up a collection budget. At least we have $420,000 left.

But this amount is in pledges over a period of three years. It is not the net value of our pledges after all, because a man who gives us a pledge to pay a dollar in three installments — 33 1/3 cents a year for three years — gives us a paper with a discount value of only 90.7 cents. That is to say, if he will give us 90.7 cents today we can invest it at 5 per cent and have as much money at the end of three years as we will have if he gives us 33 1/3 cents a year for three years. So even our $420,000 is not net after all. We finally have to deduct $38,000 more.

Certain other interest charges should be figured into our calculation but none of them is in our favor, so at last we conclude that our $500,000 of pledges have a net value no greater than $382,000.

Actual Cost of the Campaign

Incidentally, we paid out $25,000 cash for this campaign which nets us $382,000 so the cost of the campaign is not 5 per cent as is most always stated or implied. The cost of the campaign itself is at least 6.8 per cent of our net return.

In such a campaign the question naturally arises as to how costs and debits may be decreased so that net results may be improved. Generally speaking, there is only one solution to the problem. Efforts to obtain voluntary support for an institution should not be confined to an isolated campaign for funds. A subsequent promotional program seeking continuously to obtain gifts should be inaugurated. The tone of the program should be educational, interest arousing, in character.

Such an organized effort will much more than offset the nonpayment of pledges made in the initial campaign by obtaining additional pledges. The publicity and cultivation methods of the continuous program will also stimulate a higher percentage of payments on the initial pledges and the continuation program can completely absorb the collection activities without much if any additional cost.

In this way two of the largest debit items are practically eliminated, to say nothing of the fact that the low pressure continuation program is in most situations the more rational and economical method of obtaining funds and gives assurance of methodical development of the institution's scope and activities.

Editorials

Special Aid for the Rural Hospital

TWO subjects at the present time demand serious attention from the hospital field. First is how to give greater help to small hospitals so that they, too, may exemplify the best in American hospital service. The importance of this question is indicated, in part at least, by figures from the latest standardization report of the American College of Surgeons. In last year's survey 94.6 per cent of the hospitals of 100 beds and over were fully or conditionally approved, 66.0 per cent of the hospitals of 50 to 99 beds won this recognition, but only 27.2 per cent of the hospitals of 25 to 49 beds were in a position to meet the standards.

Small hospitals are not unimportant. In numbers alone they bulk large, the 3,370 hospitals in the country under 40 beds constituting 47 per cent of the total number of hospitals in the country. Excluding the special hospitals the ratio is even more impressive, as the general hospitals of 40 beds or less constitute 51 per cent of the total number of general hospitals. It is true that for the whole field, the small hospitals contain only 7 per cent of the hospital beds but these are so located that frequently they constitute the only hospital facilities available to the population they serve.

This brings up the second problem which is closely related to the first, namely, the provision of adequate hospital service within reasonable distance of all groups of the population. Approximately 1,300 of the 3,073 counties in the United States have no general hospitals at all and a considerable additional number have facilities that any student of the problem would consider inadequate. Of course every county doesn't need a hospital but it is important that service be available within a reasonable distance of patients and their physicians.

To give helpful attention to these two problems the March issue of The MODERN HOSPITAL is to be devoted primarily to the subject of the small community hospital. The subject will be approached from the standpoint of need for such institutions, their administration, means of financing them and, of course, their architecture and equipment. An unusual feature of the issue will be a portfolio of floor plans and pictures of a group of community hospitals of ten to sixty beds with brief descriptions and editorial comment on each. Articles on spring planting and interior decoration will be particularly timely. While applicable to hospitals of all sizes, they are designed to be of especial help to smaller institutions. Canada's extensive experience with small hospitals will be drawn upon in several ways.

While this issue will be devoted primarily to the rural community hospital, no reader who claims to have a serious interest in hospitals can afford to overlook the highly significant material that it will contain.

Matthew O. Foley

IT IS with deep and sincere regret that The MODERN HOSPITAL records the death on January 4 of Matthew O. Foley, editorial director of *Hospital Management*. During the fifteen years that he occupied that position Mr. Foley had become one of the best loved figures in the hospital field. Kindness, courtesy, sincerity and industry were his dominant personal traits. Outstanding among his professional attributes was a vivid grasp of news values.

To Mrs. Foley and the family of ten splendid children, to his business associates, and to the hospital field in general, The MODERN HOSPITAL expresses warmest sympathy for his premature death.

Social Security and the Hospitals

PRESIDENT ROOSEVELT has placed his recommendations regarding unemployment insurance, old age pensions and retirement annuities before Congress and the country. These, together with other recommendations regarding public health work and special provisions for mothers and children, are summarized in this month's news pages.

While the joint committee of the three national hospital associations has not yet made any announcement of the stand it will take on these measures the attitude of the American Hospital Association has long been on record. In 1931 the committee on employees' retirement, under the chairmanship of Robert Jolly, recommended adequate retirement allowances for hospital employees and the following year recorded its opinion that "some day hospital employees will also be protected by unemployment insurance which will tide them over periods of business depression resulting in reduced hospital occupancy necessitating forced leave of absence or discharge." In its 1931 report the committee stated:

"Of all the organizations known to man it seems to us that our hospitals ought to be shot through and through with a spirit of altruism not only to patients but to employees. It will be hard to impress our employees with their obligation to those who come under their care if they themselves feel that their own institution is not exerting itself honestly and faithfully to care for them when they come to the time of need. . . . This matter is not alone one of sentiment. Really it is good business."

While the bills presented in Congress to carry out the President's program may and should be carefully scrutinized to detect weaknesses and loopholes, it would be shortsighted for hospitals to oppose them simply because they entail an additional financial obligation. The cost will bring real benefits to hospital employees. The discouragingly slow pace at which retirement plans have been voluntarily inaugurated by hospitals appears to justify the belief that only with governmental aid and propulsion will such plans be widely adopted.

A Deadly Menace

ONE of the dread infections of both war and peace time is that with a gas producing organism. The Bacillus aerogenes-capsulatus is capable, when introduced beneath the skin surface, of producing widespread gangrene of the part together with a severe toxemia which is capable of quickly terminating life.

The intestinal tract of the average person, sick or well, teems with organisms most of which while capable of producing gas are fortunately of low invasive power. But it is believed that these same germs may so vary in virulence or the resistance of the patient may so wane that if they are introduced into the subcutaneous tissues great harm may be done. If this be true, the care of the hypodermic tray and the sterilization of the skin are procedures which if improperly performed may endanger life. Recently the lives of two hospital patients were put in jeopardy by a gas infection of the arm following an ordinary hypodermic injection of a cardiac stimulant. Indeed, in one case life was saved only by a prompt amputation. In the incontinent patient a fecal soiling of the skin surface may be the source of such an infection.

It should only be necessary to direct attention to such a possibility to suggest effective preventive measures. The hypodermic technique cannot be too rigidly taught and practiced. Every skin or vein puncture presents potential dangers to the patient. Hence, to place the responsibility for such apparently simple procedures on an untutored pupil nurse is an act of the greatest folly.

New Interest in Group Hospitalization

HOSPITALS interested in starting group hospitalization plans in their communities are to receive help from a new and, perhaps, unexpected source. The General Federation of Women's Clubs has decided to make "Group Budgeting for Hospital Care" one of the subjects for study and discussion by its members during the coming year.

In accordance with this decision, which does not necessarily mean an endorsement of the plan by the federation, a statement about group hospitalization has been prepared and sent out by the federation's advisory board on public health and child welfare. Dr. Hugh S. Cumming, surgeon-general of the United States Public Health Service, is chairman of this board.

The statement points out that the cost of severe illness, because of its unpredictability, cannot be budgeted under the every-family-for-itself policy. "Under these circumstances," it continues, "many families let the taxpayers or philanthropic contributors pay the bill. Even in normal times, about a third of the hospital admissions for severe illness are 'free' in local or state hospitals. . . . Self-supporting, self-reliant Americans will welcome a plan whereby hospital services can be placed on a self-supporting basis."

The federation is now preparing a bibliography on the subject. Hospital administrators, also, can help by answering questions and providing information to the clubwomen in their own communities. It is an opportunity that should not be missed.

Time To Buy

"TO EVERYTHING there is a season and a time to every purpose under the heaven." Thus is stated in Ecclesiastical language the fact that there is an opportune — an optimum time for the carrying out of every purpose.

During the past years it has appeared that the hospital field was passing through a time suitable for curtailing every possible expense. The pendulum now swings toward a period in which the activities of the hospital director should be focused upon other ends. Private room incomes are increasing. Soon endowment returns will swing upward. The market now in surgical supplies, furnishings and equipment is favorable to the buyer. Too late will the overly cautious executive realize that prices have more or less abruptly risen.

'Tis now the time to buy. Not the type of buying,

however, which sacrifices quality for price. Surgical instruments which are too cheap will soon need replacement at top figures. Furniture and hangings, shoddy and of poor texture, will hardly last the year out. Buy from recognized dealers whose promise of quality can always be taken at face value.

Echoes From a Past Generation

THE doctor of the old school to many is still the exemplification of all that is fine and courageous in the medical practitioner. To him there was but one right and fair way to deal with his medical colleagues. None truthfully could accuse him of proselyting patients or of backbiting or malicious gossiping relative to the shortcomings of his medical brethren. Every hospital staff is the proud possessor of many physicians of this type.

And yet there are those possessed of petty souls and grasping characters who offend deliberately the code of medical ethics so revered by their professional forebears. By so doing they bring reproach upon the hospital in which they labor.

No quarter should be shown such physicians if their sins of omission or commission are deliberate. Fairness to the remaining ethical members of a staff and to the good reputation of the hospital dictates the prompt and uncompromising removal of such offenders from places of trust in the institutional family.

The X-Ray Director as a Staff Member

THERE is being agitated in certain sections of the hospital field the question of the staff standing of the x-ray director. There are those who are urging that the roentgenologist should be something more than a mere technician who exposes, develops and then interprets films. Coming from within this specialty one hears loud voices insisting that each time the plate of a private patient is interpreted, the x-ray director should be paid a consultant's fee. More conservative roentgenologists believe that the hospital should not profit by the activities of this department and its personnel.

Indeed, throughout the field a profit on the year's work of the radiologic department is a rarity. Most good hospitals are content with a fine scientific output and an approach to the balancing of this department's budget. Those who demand a consultant's fee for reading each plate on private and semiprivate patients should look well before they leap. There are many surgeons and internists who are perfectly capable of reading the average plate without the assistance of a radiologic specialist. The incomes of x-ray directors often would be much diminished should this consultant policy be adopted, many clinicians and surgeons saving this expense to their patient by reading their own films. Moreover, no doubt were such a plan to be pressed not a few hospital directors would be inclined to engage a nonmedical yet highly skilled technician for the supervision of the routine work of the department only calling a staff roentgenologist when difficult cases presented themselves.

The radiologist has not been badly used in the past by hospitals generally. He should receive continued fair play from the institutional field. He is cautioned to urge no readjustment of his duties and prerogatives until he is certain that such changes will react not only to his own advantage but also to the advantages of patients generally.

After the Conflict

AT THE initial battle of one of America's great conflicts a huge army, well equipped but not accustomed to gunfire, bolted in a body and, casting away their firearms, fled for their lives. An orderly retreat, in the minds of historians, would have permitted reforming and a possible subsequent victory.

Mob panic is an unreasoning force that must spend itself in physical flight until exhaustion supervenes. Hospitals early felt the effects of a disorderly retreat from an unseen foe. Panic seized the souls of administrators. They discarded their old and tried weapons — ethics, cool business judgment, confidence in the future — and fled ingloriously to the rear. But the din of the conflict is dying away. Fear is fading. Old ideals, a calm belief in the security of the hospital's existence, personal equanimity are returning with the increasing tide of patients in the private department. The hospital has weathered the assault.

The lessons learned relative to the most efficient methods of repulsing the wild charge of an economic foe should not be forgotten. The elimination of nonessentials, of frills, of untried practices; the maintenance of a low overhead; the adoption of a simplified architecture; the curbing of unnecessary new building, are but a few of the safety first items to be borne in mind. Moreover, changing the metaphor, the hospital that possesses such a degree of flexibility that it can quickly adapt itself to the changing economic winds of the times will more successfully weather the gales that arise.

What the Administrator Should Know About Pneumonia*

With this article begins a short series of discussions concerning various types of disease, some seasonal, some particularly interesting, some difficult and expensive to treat. In the twilight zone where the administrative and the medical aspects of hospital management merge, the superintendent who has informed himself regarding some basic facts relative to disease is capable of giving greater service than he who confines himself to the purely physical in the conduct of his institution

PNEUMONIA or pneumonitis is a seasonal disease. It takes the lives of 100,000 persons annually in the United States. Pneumonia or inflammation of the lung may be of two general types. It may be sudden in onset and sudden in departure, and may involve one or more whole lobes or sections of the lung. The young and sturdy are affected with this type of pneumonia. Again, about 40 per cent of pneumonia cases are insidious in onset and affect only parts of one or more lobes. It can be seen, therefore, since the months of January, February and March are most likely to bring an influx of pneumonia cases to the hospital, and since pneumonia is distinctly contagious, that the disease should be of interest to everybody concerned with hospital work.

It has been remarked that lobar pneumonia is a disease of the strong and young, and that broncho-pneumonia affects the very young and the very old. This is an ancient disease described by Hippocrates about four hundred years before the Christian era. It is found in all climates, even in the torrid zone. Males are most often affected. Injury to the chest as a result of accidental trauma, frequently predisposes.

It is a common occurrence for patients brought into the accident ward, following injury by automobile on the public highway, to develop within a few days a high fever and many other classical signs of inflammation of the lungs. Pneumonia often follows exposure to cold following the administration of ether and the inhalation of infectious material from unclean mouths.

The lay superintendent should know something about why pneumonitis sometimes develops subsequent to a patient's admission to the hospital. It should not require a medical degree to appreciate the wisdom of providing enclosed and heated corridors leading from wards to operating rooms or of eliminating exposure hazards in the transportation of patients to and from admission and treatment wards. Usually, the practical application of such knowledge is left to the nurse or to some young and untrained physician, whereas the superintendent in his daily inspections might easily correct such defects without being requested to do so by an often too busy member of the visiting staff.

When hospital architecture is such that surgical wards are separated from the operating suite by badly ventilated and heated corridors, the institution subjects the patient to a disease risk often greater than the risk involved in the surgical operation. Incidentally, it may be remarked that hospital patients, often of low vitality and resistance, are unduly exposed to transmissible diseases such as pneumonia, tuberculosis and other catarrhal states because of lack of understanding or because of inaction on the part of medical or nonmedical hospital officials.

It should be of interest to all to know that it was not until 1880 that any information existed as to the bacteriologic cause of this condition. It was then that Sternberg inoculated a rabbit with his own sputum and isolated an organism later found to be the specific cause of the disease. Pasteur contributed much to this subject by reporting one year later an organism he had isolated from the

*Practical Administrative Problems Series.

saliva of a child who succumbed to hydrophobia, but it was left to Frankel, in 1884, to isolate definitely the cause of lobar pneumonia.

The superintendent of the hospital is often requested to purchase a specific and expensive serum for the treatment of pneumonia. Much information now exists in medical literature relative to the fact that the pneumococcus is not a separate organism but represents but one of a pneumococcic family. Most pneumonias are caused by one of four types of organisms which are dominated numerically as follows:

Type I, which is the causative organism in approximately 35 per cent of all cases.
Type II, which comprises about 25 per cent of the group.
Type III, which comprises about 10 per cent.
Type IV, which comprises about 30 per cent.

Delay Is Criminal

It is of vital interest also to the patient and to the physician that these types vary greatly in mortality. Pneumonias of Types I, II and III cause death in from 30 to 50 per cent of the cases, while Type IV is less often fatal, 10 to 20 per cent of these patients dying.

The superintendent is often importuned to purchase material for the quick determination of the type of pneumococcic infection. This procedure requires the purchase of white mice, and of a serum of known type. When he understands that there has been prepared a specific serum for Types I and II, which greatly decreases the seriousness of the condition and when he knows that the recovery of patients suffering with pneumonia is greatly aided if the serum is promptly administered, that is, within the first forty-eight hours, it will not require excessive urging on the part of the doctor to secure speed in providing the remedy. In these modern days, it amounts to nothing less than criminal negligence for a hospital either to deny the patient facilities by which the type of a pneumonia may be quickly ascertained or to delay in providing the specific serum.

Now, it can be remarked that with pneumococcic serum costing approximately $7.50 a dose, the expense to the hospital of treating these patients properly throughout a winter season is not small. And yet, no matter what the expense, the admission of patients suffering with pneumonia, whether they be in a private room or in a public ward, implies the acceptance of a responsibility that cannot be lightly evaded.

There are physicians today, particularly in outlying districts, who prefer to treat these patients expectantly, that is, to stand by and apply cardiac supportives only when needed, being content to omit the use of specific measures. It is the general feeling of the medical profession, however, that the public deserves better at its hands than this.

There is another practical angle to the treatment of this disease which the superintendent should understand and regarding which he should accept responsibility. Physicians have long known the necessity for a rather definite isolation of these patients. Moreover, the ward in which these patients are treated, should possess facilities for freely admitting fresh air even in the coldest of latitudes. It is a well known fact that the pneumococcus escapes from the body in the sputum. And here, the responsibility of the training school enters. Nurses who are assigned to the pneumonia service should not only be provided with proper protection against the cold, but also should be thoroughly drilled in preventing infection to themselves. In some institutions, gowning and even masking are required of the nurses. Surely, provisions for destroying or sterilizing sputum infected gauze and bed linen should be provided.

It is interesting to note that physicians and nurses who are brought in close contact with Type I pneumonia, for example, are more likely to harbor in their throats this specific variety of pneumococcus than others not so exposed. Moreover, many instances are noted in the medical literature in which several members of the family have suffered with the same disease. Knowing these facts, the superintendent must quickly respond to a request for the provision of proper isolation facilities when this suggestion is made by the doctor, or he must initiate such precautions himself.

Protection Needed for Delirious Patients

There is no condition more challenging to the interest and skill of the physician than pneumonia. Stormy in its onset and continuing for from seven to ten days, dramatically abrupt in its recession, the crisis in pneumonia resembles a miraculous transition from a state apparently threatening death to one of relative ease and assured convalescence.

The early chest pain often erroneously thought to be caused by the fracture of ribs or other chest injury following an accident, and extreme shortness of breath with cough and bloody expectoration are all classical in nature. Frequently, a patient suffering with pneumonia becomes delirious; this is particularly true in the alcoholic. The isolation suite provided for the treatment of this disease should be so constructed that the patient is protected from himself. One accident which occurs too frequently in hospitals is the escape of a toxic and delirious patient from his bed during the absence of the nurse, and the occurrence of a subse-

quent injury resulting from a fall from a high place or from exposure to the elements. The superintendent has a definite responsibility in regard to this matter. Windows if opening to the outside atmosphere should be properly guarded so that a delirious patient cannot fall therefrom.

It has been remarked that a patient entering the hospital for some medical or surgical treatment may contract pneumonia during his institutional stay. Improper nursing technique which fails properly to prepare the patient's mouth prior to operation, is sometimes responsible for this dire accident. An impure, and hence highly irritating anesthetic, or the exposure of a perspiring patient to a cold atmosphere on his journey to and from the operating suite, is likely to result in deadly inflammation of the lungs. Sometimes in medical wards patients suffering with heart disease develop pneumonia which is the result of the stasis of blood at the bases of their lungs.

A Commendable Practice

The practice of requiring close study of the patient by both the surgeon and the physician prior to operation is much to be commended. This is done in many hospitals. The surgeon, interested in the pathology and mechanical relief of the condition presenting itself is less likely to detect telltale evidences of pulmonary infection than is the internist. The oft noticed absence of a stethoscope from the armamentarium of the surgeon is in itself a significant fact. The therapeutic approach of the surgeon and of the internist are altogether different. Alone each leaves something to be desired, and the patient greatly benefits by their combined judgment as to prognosis and treatment. Hence the practice of group medicine assures the patient that insofar as possible he will be able to withstand the anesthetic, as well as the shock incident to surgical care.

Incidentally, the department of anesthesia enters into the problem of preventing postoperative pneumonia. Headed by a physician as it should be, expert advice as to the type of anesthesia to be employed is often useful if not actually life-saving. The requirement that each chart contain the record of a careful examination of the heart and lungs within twenty-four hours prior to operation is largely aimed at the prevention of postoperative complications of a cardiac and pulmonary nature. Many a postoperative pulmonary infection could have been avoided had less haste been evidenced in bringing the patient to surgery when no real emergency existed.

Each hospital, therefore, that lays any pretense to modernity, should consider the winter season a time when many patients suffering with pneumonia will be brought to it for treatment. Moreover, any disease which is capable of bringing death to eighty-three out of every one hundred thousand persons in our population deserves the fear in which this condition is rightfully held.

What then may the hospital do to lower this terrifying mortality? In surveying the deaths that occur within twenty-four hours in the general hospital, one is apt to encounter not a few cases of lobar pneumonia. Indeed many of the patients suffering with this disease have been ill at home for from three to five or six days. When the condition becomes serious and the patient appears to be fighting a losing battle, the physician often urges transference to the hospital. The ambulance having been summoned, the physician in charge is frequently in doubt as to the proper course to pursue since the patient is often too ill to warrant disturbing him.

The practice of transporting pneumonics who have been ill more than three or four days, long distances to the hospital, should be strongly condemned. The advent of newer methods in the administering of oxygen has done not a little to raise false hope as to the potentialities of hospital care. To remove a late pneumonic from his bed at home, and to subject him to the effort and excitement of an ambulance ride, is to deprive him of a definite chance of recovery. In urban areas, oxygen apparatus may be rented and this type of treatment administered at home.

Prompt Hospitalization Needed

All physicians should be urged to send patients suffering from lobar pneumonia to the hospital promptly, rather than to wait until the trip is likely to work greater harm to the patient than can be counteracted by the good derived from hospital care. The superintendent may well insist that staff action be taken which will definitely encourage early application for hospital treatment for these patients.

There should never be any hesitation on the part of the superintendent in promptly procuring proper drugs with which to treat this disease. The winter months should not be allowed to approach without the alert superintendent inspecting his oxygen administration equipment, making tight broken or deteriorated tents, overhauling motors, and in general preparing for the continuous use of this type of apparatus over a period of from three to six months.

No institution can claim to be properly equipped unless it has some modern type of oxygen apparatus at hand. There has come into use, within the past few months, the practice of placing at rest, of splinting, the inflamed lung tissue by the injec-

tion of air into the pleural sac. This practice has long been in vogue in the treatment of tuberculosis and it seems to promise much in curtailing pulmonary expansion in other inflammatory processes such as lobar or broncho-penumonia. Hence in addition to the equipment which has been suggested, some type of apparatus for the performance of pneumothorax should be provided.

Finally, there are certain conclusions which may be drawn on the part of the superintendent relative to this interesting disease. In the first place, pneumonia is a widespread and deadly condition. It has been rightfully called one of the "Captains of the Army of Death." It is a seasonal disease which makes possible the proper provision for its treatment long before these patients begin to apply for admission to the hospital. It is a condition which should not be treated in the open ward, which requires special and not inexpensive physical quarters. Laboratory facilities for the detection of the type of organism producing the infection must be immediately and continuously at hand. The hospital drug store must be equipped to supply on a minute's notice the specific serum, once the type is discovered.

An institutional campaign should be waged to secure as early as possible the presence of these patients in the pneumonia ward. The transportation of late pneumonics over long distances should be strenuously opposed. Proper provisions must be made to protect pupil nurses, interns and others from contagion. X-ray facilities must be generously provided for the proper study of these patients at the bedside. The transportation of patients with lobar pneumonia to the x-ray department should be interdicted. This contemplates, of course, the presence, in the hospital, of an adequate portable x-ray machine. The use of these patients for clinical teaching should be discouraged and every effort should be made to provide the physical and mental rest which is often life-saving.

Such is the picture from the practical standpoint of this seasonal disease known as lobar pneumonia. When a condition is prone to destroy those of advanced years it is regrettable, but when a disease such as this has a peculiar predilection for those passing through the most productive period of their lives, its presence and the menace it carries to life are alarming. Any assistance, therefore, which the nonmedical superintendent may render through his better understanding of the tendencies of the disease, is not only desirable from the standpoint of duty but is necessary from the angle of the patient's chances of recovery.

Hospitals Can Save by Buying Ether in Large Drums

A study was undertaken recently by Dr. Harry Gold and David Gold, both of New York City, to ascertain the rapidity of deterioration of U. S. P. ether under ordinary conditions after the metal containers in which it is commonly marketed in the United States have been opened.

A series of specimens of ether were collected from nine different hospitals and ten different laboratories in New York City. The sources of these specimens, according to the labels, were five different and well known manufacturers or distributors. The method and results of the study are described in detail in a recent issue of the *Journal of the American Medical Association*. Following are a few highlights from the article.

A Word of Warning

"While examining a record of the drugs dispensed in one of the hospital pharmacies, we observed that ether was listed under two headings: (1) 'Ether U. S. P. in twenty-seven-pound drums at eleven cents a pound,' and (2) 'Ether for anesthesia in quarter-pound cans at sixty-three cents a pound.' The cost of ether in the small cans was therefore nearly six times as much as that in the large drums, although the latter had been filled with ether which complied with standards for purity set up by the United States Pharmacopeia for ether of anesthetic quality.

"The latest edition of the United States Pharmacopeia (U. S. P. X.) makes the following statement in italics in the article on ether: 'Caution—Ether to be used for anesthesia must be preserved only in small, well closed containers, and is not to be used for this purpose if the original container has been opened longer than twenty-four hours.' "

What the Study Shows

The authors, however, disagree with the above statement. They have reached the following conclusions as a result of their study:

"1. U. S. P. ether in metal cans, as it is supplied in this country at the present time by the better known manufacturers, does not deteriorate rapidly under ordinary conditions when the metal containers are opened. The present study shows that the can may be opened and again stoppered with cork many times during periods of weeks without oxidation detectable by the U. S. P. tests.

"2. There is no evidence that ether specially purified 'for anethesia' has any material advantage over ordinary U. S. P. ether for anesthesia purposes.

"3. It is recommended that hospitals buy ordinary U. S. P. ether in large steel drums and that for anesthesia the operating room be supplied with ether in small tin cans filled daily from the drums by the hospital pharmacist. The ether in the drum may be tested daily for aldehydes and peroxides, there being very simple tests for each requiring only from five to ten minutes to perform. This would help to correct an erroneous view regarding the speed of deterioration of ether after the container is opened and to abolish the extravagant practice of buying ether in hundreds of quarter-pound or half-pound cans at from four to six times the cost of ether in drums, when large quantities of ether for anesthesia are used."

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Conducted by JOHN C. DINSMORE *and* DR. R. C. BUERKI

Getting Value From Your Oxygen Tent

By WAYNE TAYLOR, M.D.
Lufkin, Tex.

OXYGEN therapy technique is just as vital as the technique of any medical procedure in the diagnosis and treatment of disease. It is the duty of those who sell oxygen tents and of doctors and hospital superintendents to instruct nurses concerning the handling of the tents and the administration of the treatment. It is lamentable to know that oxygen tents are usually ineffectively operated, a fact which often leads to their disuse because of unpropitious results.

These facts have been learned through careful scrutiny of the technique practiced in the operation of oxygen tents in many hospitals in the United States. I have found that oxygen tents are usually operated by incompetent nurses and orderlies who have received little instruction in how to handle them. Following are questions put to one orderly in a modern university hospital and his answers.

An Orderly Answers Some Questions

Q. "What liter flow of oxygen do you give and is the tent purged during nursing procedures?" *A.* "Five liters of oxygen are flowing and we never purge the tent with oxygen when the ice chamber is refilled or nursing procedures are undertaken." An oxygen tent with this type of operation would show an oxygen concentration during a twenty-four-hour period of about 25 to 40 per cent oxygen and it is readily seen how ineffective it would be because there is no storehouse for oxygen.

Q. "How often do you replenish the soda lime container?" *A.* "It has not been changed in the three months that I have been working here."

Q. "Do you use a rubber sheet under the patient to save oxygen?" *A.* "No."

Q. "Do you use a weather thermometer to see if it is cool under the tent?" *A.* "No."

Q. "Does the patient ever complain that it is too hot under the tent?" *A.* "Yes, often."

Q. "How often is a gas analysis done?" *A.* "About once each day."

Q. "Does any doctor ever question you in regard to the oxygen concentration, the temperature under the tent, the carbon dioxide under the tent and the number of liters flowing?" *A.* "No."

Q. "Who taught you how to operate this oxygen tent?" *A.* "The orderly who worked here before I took this position."

This is an illustration of the answers that I get in visiting many good hospitals. In one university hospital I asked a nurse who was caring for a case of heart disease if her patient was comfortable in the tent and her reply was, "He said it was too hot but stated that he would resign himself to the treatment if the doctor thought it would help him." It is evident that if oxygen tents are used in such a manner they are practically worthless.

For the proper application of oxygen therapy the following conditions must be maintained.

1. There should be a large tent enclosure of about 20 cubic feet, well ventilated to relieve the sense of restriction. Many patients have psychic disturbances when placed in an oxygen tent because of fear and the confining influence of the tent. This may be subdued to a great extent by the use of large tents and by explaining away the fear. A large adult with very high fever will naturally require a greater cooling effect and a large tent. For children a small tent is satisfactory.

Using the Tent Effectively

A rubber sheet should be placed under the patient and the tent tucked under the rubber sheet to save oxygen and to maintain the coolness of the atmosphere. When the patient is bathed and other nursing procedures are undertaken, the lower end of the tent should be brought up over the chest to maintain for the patient the same atmospheric conditions. All seams and window connections should be cemented and should be inspected frequently for leaks. A good tent material, if the tent is used a great deal, will not often last longer than six months because of the harmful effect of oxygen upon the rubberized material.

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When you provide PALMOLIVE, you gain the approval of both doctors and patients. For doctors know, as do you, that a mild, neutral *olive oil* soap is soothing even to the most sensitive skin. And Palmolive is the *only* popularly priced soap that's made exclusively from olive and palm oils.

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Besides being the type of soap your medical staff recommends . . . the soap most patients prefer . . . Palmolive is economical! Actually, *it costs no more* than many less popular brands.

Find out how little it costs to provide this important detail of patient comfort! Write to us for prices. We'll send, too, our helpful *free* booklet: "If it's soap you need, we have it." No obligation, of course. Why not write today?

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2. An ideal temperature is usually 10 to 20 degrees below the room temperature. In summer with a room temperature of 90 degrees, the patient should be exposed to a temperature of 70 degrees, therefore a tent temperature of 55 to 60 degrees should be maintained. Of course, there are exceptions to this rule in treating infants and patients suffering from shock. It is difficult to explain why a temperature below room temperature should be desired even though the room temperature is 70 degrees. Why do patients often complain that "it is too hot under here," when they are exposed to a temperature the same as the room temperature? Why do they complain that it is too hot when the temperature is 10 and 15 degrees below the room temperature? I should think that the coolness of the atmosphere would offset this feeling due to stale atmosphere, given these lower temperatures.

Why Patients Object to Tent

It is surprising to find that many oxygen tents in the United States are not operated in such a way as to maintain a comfortable temperature, thus they defeat the purpose of the therapy, namely, rest. A patient may wish to leave an oxygen tent for one of three reasons: (1) psychic influence due to confinement; (2) the temperature and humidity may be too high; (3) too much carbon dioxide or stale air may be present.

A proper cooling and humidity effect is obtained in oxygen tents by circulating air through an ice chamber by means of a motor blower, an injector or convection circulation.

A 50 per cent oxygen concentration should be maintained by a 4 to 6-liter flow. Any procedure that involves opening the tent makes it necessary to purge the tent with oxygen so as to bring back instantly the proper oxygen concentration. After the nurse has become skillful she understands how much purging of the tent is required and when it is necessary. The temperature in the tent, the oxygen and the carbon dioxide content should be charted in a similar manner to that which the temperature, pulse and respiration are tabulated. I insist that the nurse should learn all these details concerning the operation of an oxygen tent because she is the one in constant attendance on the patient.

It is true that oxygen therapy is expensive but it compares favorably in this respect with other therapeutic measures. Frequently we hear the remark, "Don't use so much oxygen because we cannot stand the expense." On the other hand, we hear this remark, "Don't save oxygen and lose the patient." The basic principle of good oxygen therapy is frequent analysis of the atmosphere. The usual patient requiring oxygen therapy should be maintained in a concentration of 50 to 60 per cent continuously. However some patients will be relieved with lower concentrations but these lower borderline concentrations should not be employed by persons not having a great deal of experience in oxygen therapy.

No oil or grease should be used with the gauges. Oxygen under high pressure coming in contact with anything inflammable strongly supports combustion. Before attaching the regulator the oxygen drum should be open slightly to blow out any dust, thus avoiding injury to the regulator. Special warning should be given concerning the use of inflammable substances in an oxygen tent, particularly matches, cigarettes, alcohol and electric pads. No open fire should be permitted in the room in which an oxygen tent is being operated. The oxygen tent will have to be removed for x-ray and diathermy work.

All tents should be sterilized immediately after use. Scrubbing the tent with a solution of bichloride of mercury will serve well for this purpose. Proper care of a tent will go a long way in prolonging its usefulness and effectiveness.

Since the average person exhales about 5 per cent carbon dioxide at each exhalation this carbon dioxide must be removed from the oxygen tent. This is done by two methods. (1) The use of soda lime placed in the path of the circulating atmosphere. Carbon dioxide should not accumulate above 1½ per cent. The only way to determine the efficiency of the soda lime is analysis of the tent atmosphere to discover if the carbon dioxide is being absorbed. A gallon of soda lime will usually last for four or five days of continuous therapy. (2) A great deal of carbon dioxide escapes through the rubber fabric. In most oxygen tents with an 8 or 10-liter flow there is sufficient leakage to remove most of the carbon dioxide.

Reducing Light Glare

There is never an excuse for exposed light bulbs shining in the patient's eyes. Severe visual strain has bad effects, causes headaches and even distresses digestion. Soften all light, have it indirect rather than direct. Investigate some of the newer bedside fixtures which can be adjusted to shine on the ceiling or over the patient's shoulder while he reads. Hospitals always try to reduce noise. Let them try also to reduce light glare. It is equally undesirable.

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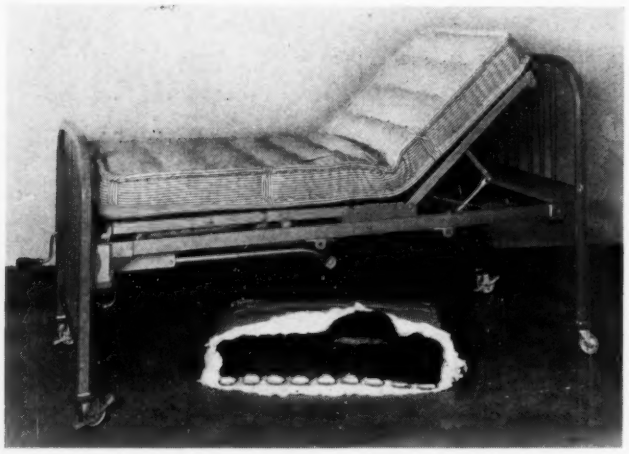
MAINTENANCE, OPERATION AND EQUIPMENT

Two Specially Designed Pieces of Hospital Equipment

By G. W. OLSON and CARL A. FRIEDMANN
Assistant Superintendent and Technical Assistant, Respectively, Los Angeles County General Hospital, Los Angeles

MANY interesting innovations are incorporated in the furnishings and equipment of the recently completed Los Angeles County General Hospital, Los Angeles. An article in the July, 1934, issue of The MODERN HOSPITAL described the construction of certain specially designed equipment used at the institution, such as bassinets, bassinet carts, cribs, adjustable beds for adult patients and bedside cabinets. Such large quantities were required that specially designed equipment could frequently be obtained at stock equipment prices.



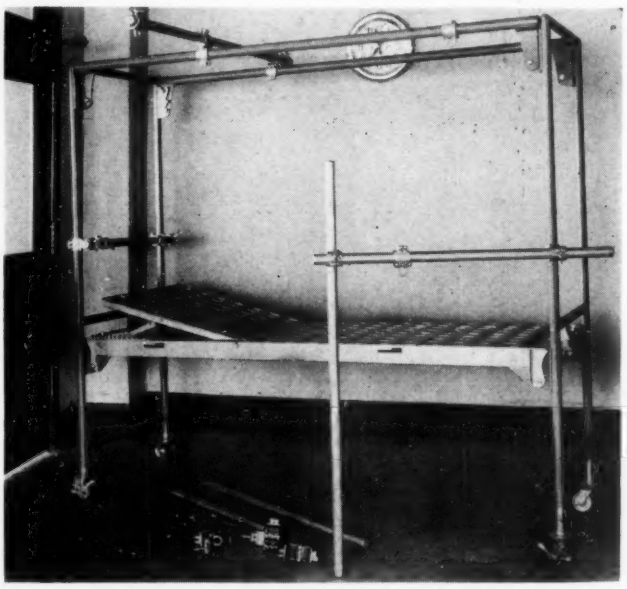
The present article describes two additional pieces of specially designed equipment used in this institution — an inner spring mattress and a fracture bed. Let us consider first the inner spring mattress.

The decision to use an inner spring mattress was based on several reasons. It was felt that (1) this type of mattress represented the latest trend in mattress design; (2) it provided greater comfort for the patient; (3) it would contribute toward a more rapid recovery of the patient, thus reducing his stay in the hospital.

In the accompanying photograph the mattress is shown with the back rest of the bed in an elevated position. The loop straps on each side of the mattress and the short safety chains and hooks attached to the bed rails prevent the mattress from sliding forward under the patient's weight. The loop straps are attached firmly about four inches from each edge of the mattress, thus allowing ample room to tuck in the bedding. There are loop straps at each end of the mattress, which makes it reversible. Each corner of the mattress and the two edges are provided with heavy ticking hand loops for convenience in handling.

The inner spring unit is of highly tempered hourglass type coils. It is enclosed in an envelope of long drawing horsetail hair woven into the outside of heavy burlap. This prevents the spring coils from working into the 100 per cent long staple cotton which forms the outer cushion. The mattress cover consists of eight-ounce standard blue striped ticking with thirty-six tufts. The tufts are arranged in nine rows with four tufts in each row. This facilitates bending of the mattress on the adjustable bed bottom.

In designing the fracture bed an effort was made to produce a bed that would: (1) provide a rigid yet ventilated bottom, with an adjustable back rest; (2) provide a frame sufficiently strong and



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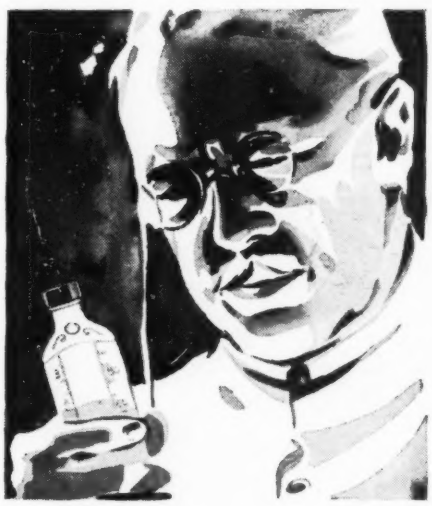
The prescriptions that patients take home with them will be in the medicine cabinet for weeks, or on the bed-side stand during further visits of the doctor. That is why prescription ware must have the clean cut, ethical appearance that does credit to your hospital. Its quality and design must maintain the prestige you build by fine administration and fine equipment.



Owens-IllinoisOvals and Emerald Green Services for drug prescriptions—build prestige and reduce costs at the same time, because O*nlzed* quality is not only obviously superior but it protects your budget against daily losses from over-capacity or defective bottles. Even more important, Owens-Illinois prescription ware comes to you absolutely sterile.

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rigid for safe handling of patients; (3) provide a simple, standard and easily operated means of attaching traction pulleys in any direction from any part of the patient; (4) permit elevation of either end of the bed up to sixteen inches; (5) permit easy assembling and disassembling for storage; (6) permit easy travel in corridors and elevators, and (7) be simple, foolproof and inexpensive.

The fracture bed as finally designed has a strap iron bottom on a channel iron frame, which is attached with the usual pin notch brackets to the head and the foot ends. These are high enough so that the projecting traction bars will have sufficient head clearance.

The head and foot ends of 1½-inch O.D. No. 13-gauge bedstead tubing are joined at the top by two bars of 1½-inch standard pipe. These bars are joined to the head and the foot ends with pin notch brackets for easy disassembling. There is also a thread and nut fastening arrangement as an additional safety factor when the beds are being wheeled over elevator sills and other obstructions. This is an important feature as in many instances patients are transported to plaster rooms on fracture beds instead of being carried on stretchers.

A supply of bars of bedside tubing of various lengths and a supply of clamps are kept on each ward. By means of the clamps, bars of any length desired may be fastened anywhere along the three planes formed by the head, the top and the foot of the bed. Also, one or more ring clamps for attaching traction pulleys may be fastened at any point on any bar. The bars may be arranged, if desired, in numerous irregular combinations.

The clamps are lined with soft leather to protect the bed members and the bars. They are fastened by means of attached swing bolts and operated by small socket wrenches. This prevents changes being made in the bars or tractions by other than authorized persons.

The bed legs are provided with 3-inch rubber tired casters which are fitted with rubber bumpers and mounted on extension stems. The bed ends and upper connecting bars are finished in lettuce green synthetic baked enamel. The bed bottom, the traction bars and the clamps are finished with one coat of aluminum lacquer and one of clear lacquer. The channel side bars at the bottom are slotted to permit use of the same guard rails as are provided for the adjustable bottom beds.

Organization Chart

Phases of administration needing greatest emphasis will profoundly affect the character and appearance of an organization chart. If a relation between departments and the numbers and duties of the employees is to be shown, then a place must be made on the chart for every employee, giving his full relationship and general duties.

This is the plan followed in the chart of the University of Chicago Clinics. Whenever possible, every person (except those on committees) is shown. At a glance it is possible to tell the relative and exact number of employees in each department shown. This chart could be used to indicate pay roll by adding the monthly pay check of each employee to the white area bearing his position.

Charts are sometimes used to show only relationship of departments to administration; these are functional charts. Others show the persons making up the department. In the former, the titles would be Business Office, Pharmacy, Admitting Office, without in any way indicating the number of persons in each department and their respective duties.

The University of Chicago Clinics used a large bulletin board of the type that is covered with black felt folded in horizontal lines. Small and uniform pieces of cardboard were used as cards and upon them the pertinent data were typed. The cards were then placed as desired and the connecting lines shown by heavy linen binding thread.

To get the maximum service from such a chart the little cards should bear the name of each person. This will at once make all employees interested and possibly save some embarrassment on questions of relative authority. Such a program calls for periodic revision but these visual records of each person's place in the organization are of considerable value to the administration.

The increase or decrease in personnel is shown graphically and serves as an excellent aid to the administrator. The board is easily photostated or photographed for permanent record purposes.

Nursing personnel is not shown on this chart. Usually it is less important graphically to represent nursing personnel because there tends to be a constantly observed ratio of nurses and nursing costs, whereas in other departments culminative changes are easily missed unless brought forcefully to attention by means of graphic records.

Color Psychology

Consider color psychologically when decorating your rooms. Color has subtle emotional influence. Warm colors —pinks, tans, buffs—are active in stimulation. Cool colors —greens, blues, lavenders—are passive.

It is conceivable that the convalescent, such as the maternity patient, will enjoy a warm environment. The effect of color will encourage recovery and suggest happy days in the near future.

Yet for the unfortunate chronic who must remain indefinitely confined, a cool, passive environment may be beneficial. You want to make him comfortable and color can help you do so.

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St. Mary's pediatrics division owes its cheerful, "homey" appearance to blue Sealex Veltone Floors set off by animal insets and borders in contrasting colors.

Attractive, cheerful surroundings—which hospital authorities know are "good medicine" for any ailment or patient—are probably of most importance in the treatment of young children.

That is why St. Mary's Hospital at Detroit, Michigan, installed Sealex Veltone Linoleum Floors and Sealex Wall-Covering throughout its pediatrics division. These materials make attractive, designed-to-order decorative effects possible at really moderate cost.

Past experience had already convinced St. Mary's that Sealex Floors and Walls meet every practical requirement. They are highly sanitary, durable and inexpensive to maintain. And Sealex Floors are quiet underfoot—less tiring to the hospital staff.

Whether for a new hospital unit or for modernizing an old one, Sealex can be quickly applied without costly preparation. When installed by authorized contractors of Bonded Floors or Bonded Walls, materials and workmanship are backed by a Guaranty Bond. For further information write:

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MAINTENANCE, OPERATION AND EQUIPMENT

A Test for Liquid Soap

A simple test for determining the percentage of anhydrous soap in liquid soap is described in the following paragraph:

Pour 20 c.c. of the soap solution into a 25 c.c. glass-stoppered graduated cylinder. Add 5 c.c. of concentrated sulphuric acid to the soap. Insert the stopper and shake the cylinder, taking care to prevent the contents from being forced out by the heat generated. Shake thoroughly, remove the stopper and allow the mixture to cool. A layer of oil will be seen floating on the liquid. Note the volume of this oil in cubic centimeters. By referring to the accompanying table, the percentage of anhydrous soap in the original sample will be indicated directly. No calculations are necessary.

PERCENTAGE OF ANHYDROUS SOAP FOR VARIOUS READINGS, USING 20 C.C. OF LIQUID SOAP AND 5 C.C. OF ACID

Reading c.c.	*Percentage Anhyd. Soap*	*Reading c.c.*	*Percentage Anhyd. Soap*	*Reading c.c.*	*Percentage Anhyd. Soap*
0.5	3.0	3.9	22.5	7.0	40.0
0.85	5.0	4.0	23.25	7.2	41.0
1.0	6.0	4.4	25.0	7.5	42.5
1.3	7.5	4.5	25.75	7.8	44.25
1.5	8.75	4.8	27.5	8.0	45.25
1.7	10.0	5.0	28.75	8.2	46.25
2.0	11.75	5.2	30.0	8.5	48.0
2.1	12.5	5.5	31.5	8.8	49.75
2.5	14.75	5.7	32.5	8.9	50.0
2.6	15.0	6.0	34.5	9.0	50.75
3.0	17.5	6.1	35.0	9.3	52.5
3.4	20.00	6.6	37.5	10.0	56.5
3.5	20.25				

Removing Cod Liver Oil From Cotton and Wool Fabrics

Cod liver oil stains and odors are difficult to remove from fabrics. Little information is available concerning their removal and the methods that have been suggested are not altogether successful.

A thesis entitled "Solvents for Cod Liver Oil Residues in Fabrics," submitted at the University of Chicago by Lettie Leola Cooper in 1931, describes the results of experiments with both cotton and woolen fabrics. The reagents used were those generally employed for the removal of ordinary fats and oils—soaps, alkalies, fat solvents and oxidizing agents. They were used alone and also in combinations.

Before applying any reagent, five drops of the oil were put on the cloth which was exposed to the air for twenty minutes to give the oil time to be oxidized so that there would be no odor. After the oily samples were treated with the reagents they were dried on a hot radiator without coming in contact with one another.

For removing the odor from the cotton sample, soaps were tried first because they are the most commonly used reagents for this purpose. The samples were boiled for fifteen minutes in 200 cc. of a 1 or 2 per cent soap solution. A stronger solution gave no better results. The odor was removed only by repeated boilings in the soap solution, and this frequently made a yellow spot. Different brands of soap required different numbers of boilings.

When fat solvents were used the samples were soaked in them for five minutes and, if followed by boiling in a soap solution, five minutes were allowed for the evaporation of the excess solvent. Neither one nor two applications of any of the solvents, when used alone, removed all the odor. Use of a solvent followed by boiling in a soap solution gave more favorable results, although all combinations were not completely effective.

In some cases it was necessary to use two applications of the solvent before boiling in a soap solution in order to remove all the odor. It was found that one application of gasoline, carbon tetrachloride, amyl acetate or ethyl acetate, or two applications of naphtha followed by boiling in a 2 per cent solution of soap flakes, completely removed the odor of the oil. The addition of an alkali to the soap which originally removed the odor of the oil prevented complete removal of the odor.

The same methods were used for wool as for cotton, except that the wool was washed in solutions at 60° C. rather than boiled. It was found that soaps were not especially effective in removing the odor of the oil from wool. Only those combinations of reagents that were successful in removing the odor from cotton were used in testing the wool. The results showed that one application of gasoline or two applications of naphtha, carbon tetrachloride or ethyl acetate, followed by washing in a 2 per cent solution of soap flakes, removed the odor of the oil from the flannel.

Removal of the stain caused by cod liver oil presented an individual problem that had to be treated separately. Although several reagents were tested, the only one found to be completely effective in removing the stain from either cotton or wool fabrics was a dilute, hot bleaching solution made from chloride of lime and water.

This study concludes that the best method for removing the odor of cod liver oil from both fabrics is to use gasoline followed by laundering in a solution of soap flakes. Gasoline is superior to all other solvents. Use of gasoline and soap flakes in combination prevents the formation of a yellow stain. Naphtha as the solvent might be preferable in some cases, although it is more expensive than gasoline and two applications are necessary to remove the odor of the oil.

Under no circumstances is it advisable to use soap alone for the removal of the odor, both because too much time is required and because a stain is formed.

Advantages of Casein Paints

Have you ever investigated casein paints? They offer advantages to hospitals, particularly as a substitute for calcimine. Although soluble in water when applied, they dry hard and can be washed conveniently. The casein medium results in a dull finish with a higher reflection efficiency than most other paints.

This paint is permanent and can be used safely over fresh plaster and cement without spotting. To wash it, a 2 to 3 per cent solution of ordinary 40 per cent formaldehyde can be added to soapy water.

Much of the outside paint used at the 1933 and the 1934 Century of Progress was casein paint. It was found to be more satisfactory for interior than for exterior work.

Are they Dropping Bombs in your Hospital Corridors?

Control Noise with Acousti-Celotex

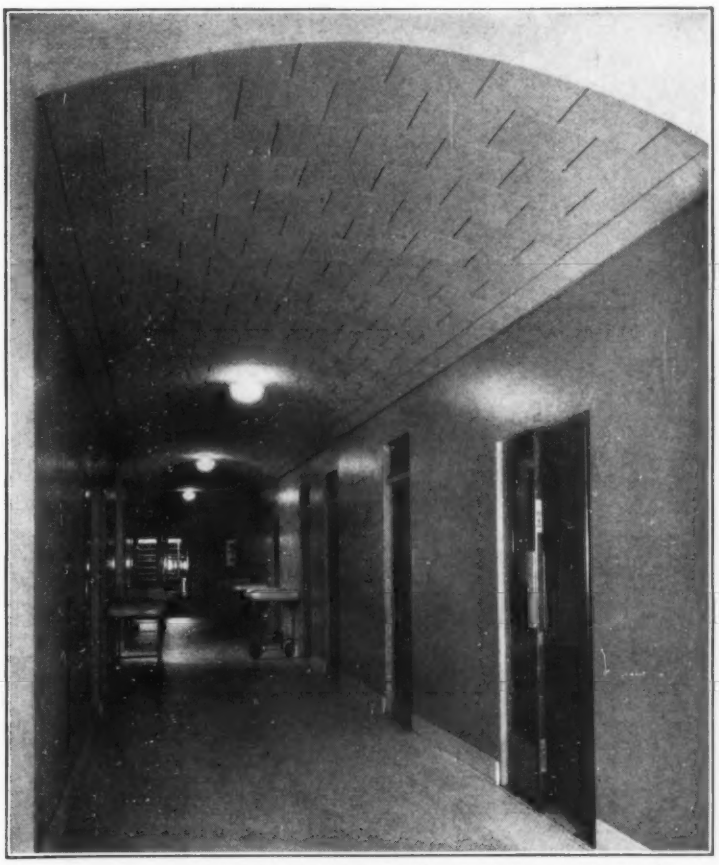
Over-sensitive nerves of patients frequently are shattered by reverberating noises from busy corridors. Perhaps an elevator door is closed too hard, dishes and pans are rattled in serving rooms, or conversation is not properly subdued, in spite of the "Quiet" sign.

Whatever the noise, it travels instantly the entire length of the corridor, reverberating between hard, sound-reflecting surfaces and building up to many times its original loudness. In the meantime, every patient on the entire floor is wondering — "Are airplanes dropping bombs outside my door?"

This evil still exists in many otherwise modern hospitals. But every year more and more institutions are solving the problem by installing Acousti-Celotex on corridor ceilings. These sound absorbing tiles effect a startling transformation. Every noise is smothered *at its source* before it can spread. The "Quiet" sign no longer depends entirely on the human element for its effectiveness.

Since Acousti-Celotex of itself is decorative, is permanent, and is easily and inexpensively installed, it is possible for every hospital to benefit from its advantages.

Where decorating is desired to conform to existing colors, Acousti-Celotex may be painted and otherwise decorated without loss of its sound absorbing qualities.



Above is a typical corridor in the California Lutheran Hospital, Los Angeles, with Acousti-Celotex installed in the ceiling.

The Acousti-Celotex contracting engineer in your city will be glad to give you, without obligation, a complete analysis and recommendation to fit your particular needs and problems. Or, write direct. Prices are lower now.

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TRADE MARK REGISTERED U. S. PATENT OFFICE

Dietetics and Institutional Food Service

Conducted by ANNA E. BOLLER, Central Free Dispensary at Rush Medical College, Chicago

How to Strengthen the Weak Points in Dietary Administration

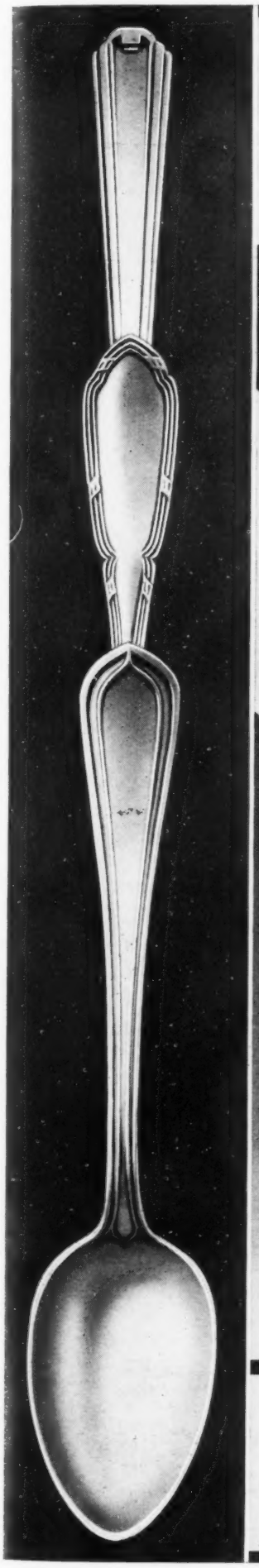
By EDITH R. TILTON
Chief Dietitian, Barnes Hospital, St. Louis

IN ANY economy program the hospital superintendent expects each department to contribute its share of the saving. The dietary department, which spends so large a portion of the hospital dollar, must find a way to reduce expenditure. Yet food standards must be upheld, for it is surely a false economy which attempts to maintain health and morale upon an inadequate diet. Therefore it devolves upon the dietitian to find ways of economizing which will neither interfere with the standards of good nutrition nor cause dissatisfaction among patients and personnel.

We believe that the best approach to the problem lies in scrutinizing the most ordinary procedures to find out whether they justify their existence. Three major factors must be considered in such a study. First, is the food purchased the best obtainable for the money spent, that is, are prices right and are those foods selected that are highest in nutritive value? Second, are all foods prepared and served in a manner calculated to encourage complete consumption, so that there is a negligible percentage of waste? Third, are employees giving a just return of service in proportion to the salaries which they receive?

The first factor, that of efficient purchasing, is

Food conveyors being filled in the main kitchen at Barnes Hospital, St. Louis.



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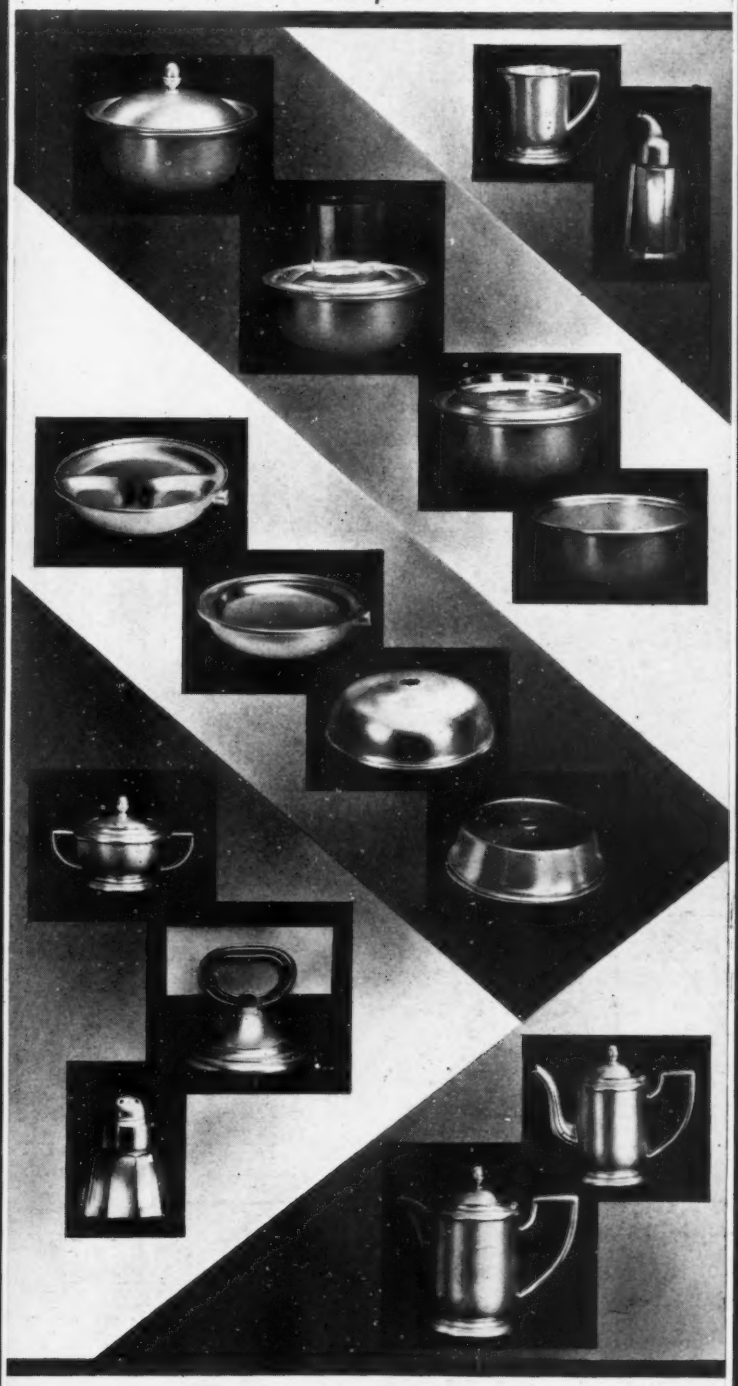

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one on which much has been written. Nevertheless, individual problems arise in different hospitals, due to variations in organization and purchasing power. It is generally conceded that the person planning the menus and supervising the kitchens is best equipped to purchase food supplies, yet this is often impractical in a given institution. The dietitian may not have time to do all her buying personally; again, the buying power may be concentrated in a purchasing agent. We have worked out a compromise scheme which has proved satisfactory and which depends for its success upon the close cooperation of dietitian and storekeeper.

LIST OF MEATS ON WHICH PRICE QUOTATIONS ARE ASKED

Beef

- Round, Choice Steer
- Round, Good Steer
- Loin End, Choice Steer
- Loin End, Good Steer
- Tenderloin, Choice Steer
- Tenderloin, Good Steer
- Flank, Good Steer
- Ribs, Choice Steer
- Ribs, Good Steer
- Chuck, Good
- Fore Shank, Good
- Brisket, Good
- Tongues, Fresh, 3-4 lbs.
- Tongues, Pickled, 3-4 lbs.
- Tongues, Smoked, 3-4 lbs.
- Oxtails
- Sweetbreads, Calf
- Sweetbreads, Beef
- Brains, Beef
- Liver, Beef
- Liver, Calf

Veal

Mutton and Spring Lamb

Pork

- Bacon, 6-8 lbs.
- Bacon, 8-10 lbs.
- Frankfurters No. 1
- Hams, Smoked, Regular, 14-16 lbs.
- Hams, Smoked, Regular, 18-20 lbs.
- Hams, Smoked, Skinned, 14-16 lbs.
- Hams, Smoked, Skinned, 18-20 lbs.
- Hams, Green, Skinned, 12-14 lbs.
- Hams, Green, Skinned, 18-20 lbs.
- Pork Tenderloins
- Pork Loins, 8-10 lbs.
- Pork Shoulders, N.Y., 12-15 lbs.
- Pork, Salt Back
- Pork Sausage, Link, Sheep Casing
- Pork Sausage, Link, Hog Casing
- Pork Sausage, Bulk, Pure
- Spare Ribs
- Liver, Hog

Poultry

- Hens, 5-lb. average
- Hens, 3½-lb. average
- Broilers, 2 lbs.
- Friers, 3-3½ lbs.
- Squabs

In general, foods purchased are divided into three classes: groceries, meats and fresh fruits and vegetables, all of which are bought on a system of competitive bids. Of the groceries, staples such as flour and sugar are bought by the storekeeper, who prepares a list of monthly needs and obtains quotations. If a certain grade proves unsatisfactory, a change may be made after tests are carried out in the kitchen to determine a more satisfactory kind.

Canned goods are bought for a year in advance, although market conditions may make it necessary to vary this practice. In buying canned fruits and vegetables, a case of each brand is submitted for sampling. The grades desired, as Choice, Fancy or Standard, as well as the size of cans, are specified in asking for the samples. A can from each case is then opened and inspected without reference to brand or price. The dietitian makes a choice of a first, second and perhaps third, on the basis of appearance, size of pieces as to suitability for purpose, flavor, weight of pack and of drained contents. After these selections are made the price is consulted, and the brand chosen that will be the most advantageous and economical. A second can of that brand is opened for comparison with the first, to see if they are uniform. The storekeeper then places the order with the approval of the superintendent or his representative. The remaining cans from the selected brands are reserved for comparison with the new purchase when it is delivered.

In buying meats, one needs to know the kinds that will be best for the particular requirements. There are always discussions as to the relative merits of buying whole carcasses, sides, quarters, as compared with buying cuts. We ran a series of tests to find the answer to our own problem. We wished to compare the cost of buying whole beef carcasses with the cost of buying cuts. This was done by making two sets of menus for four weeks each, in which the beef dishes served were identical. We then tabulated our data for the two periods as follows: average number fed daily; total pounds beef bought during week; total cost of beef for week; pounds (A.P.)[1] used per person per week; cost of beef per person per week; average price per pound (A.P.).

As a result of this survey, it was found that buying the beef cuts, such as round, shank, hip and chuck, meant an actual saving of approximately 40 per cent on identical menus.

This is but one instance of applying real figures to a procedure which has previously been taken for granted as best. Much the same type of work has been done with other meats, in an attempt to find the sizes and grades on which the most value per cent per pound will be realized. Is a cheap bacon really cheap or do you lose your saving in wastage and in cooking? You may be astonished at the result of working out tables such as this:

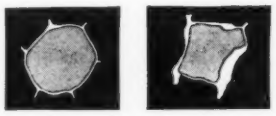
Price per pound A.P.
Weight A.P.
Weight of rinds and trimmings.
Weight raw after trimming.
Weight after cooking.
Weight of grease lost in cooking.
Price per pound E.P. after cooking.

The most striking example we found was the fact that a brand of bacon costing one and one-half

[1]Terms used: A.P. for As Purchased; E.P. for Edible Portion.

They'll like it for breakfast...

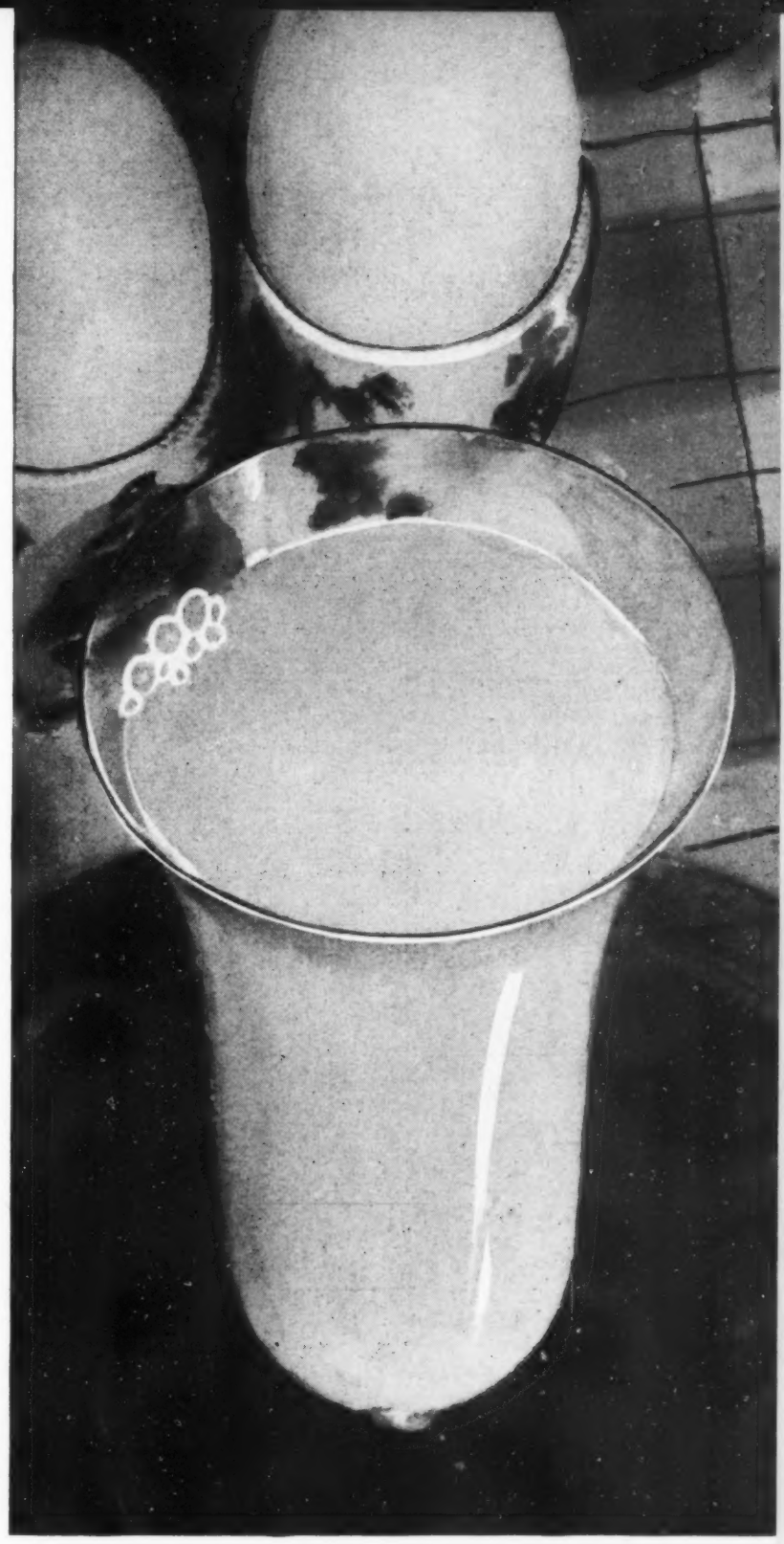
this tangy pineapple juice rich in Esters



FINER FLAVOR — the glorious tangy flavor of Hawaiian pineapple fully ripened in the field! This juice of Libby's *has* it. For Libby's is the natural juice, unsweetened. And it's *rich in Esters!* Esters are the flavor-carriers concentrated in the full-ripe fruit cells like the one at the left above. Libby takes the juice from these cells; then seals it in containers by a special method that protects the Esters.

RESEARCH SHOWS that Libby's Pineapple Juice has the nutritional values you look for in a fruit juice, is a notable protective food. It is a good source of Vitamins A, B, and C; it is alkaline in reaction; it supplies iron needed by the blood, and copper. Important too, its nutritional values are uniform the year round.

SUCH A TIME-SAVER! Busy hospital kitchens welcome this fruit juice that needs only chilling to serve. No squeezing or straining. And how pleased patients and staff are to see something different for breakfast! The natural unsweetened juice of Hawaiian pineapple, tangy and refreshing, a glass of Libby's is the ideal way to start the morning. You can get Libby's Pineapple Juice from your usual source of supply. Libby, McNeill & Libby, Dept. N-53, Welfare Bldg., Chicago.



● *Libby's 100 Fine Foods include Fruits and Fruit Juices, Vegetables, Pickles, Condiments, Canned Meats and Evaporated Milk. They are packed in regular and special sizes for institutions*

Libby's Pineapple Juice bears the Seal of Acceptance of the American Medical Association's Committee on Foods

Libby's HAWAIIAN PINEAPPLE JUICE UNSWEETENED

cents less per pound than another, A.P., was in reality seven cents higher per pound E.P. after cooking.

After a series of such trials, we were ready to make a list of the meats — cuts, sizes and grades — on which we wished quotations. In order to keep advised of market changes, the dietitian telephones the various packers for quotations on all items once a week. After marking the ones that appear to be the best buy, she gives one copy of the list to the storekeeper for use in ordering for the week. Changes in price during the week are called in by the firms who have quoted prices. The list used is a fairly comprehensive one, as will be seen by the table on the preceding page.

The carbon copy of prices which is kept by the dietitian enables her to forecast the cost of her menus and to change an item which is temporarily high, substituting a less expensive one. Without this advance information she may often be dismayed at the high cost of some cut which has previously been cheap.

A procedure somewhat similar to the meat purchasing is followed with the fresh fruits and vegetables. We have listed all the items which we ordinarily use, and prices on all those in season are obtained through the dietitian's office, care being taken to have specified the weights and grades.

LIST OF FRUITS AND VEGETABLES ON WHICH PRICE QUOTATIONS ARE ASKED

Fruits

Apples, Cooking, bu.	Grapes	Pears, Table, box
Apples, Table, box	Grapes, Seedless	Pears, Cooking, bu.
Apricots	Grapefruit	Persimmons
Avocados	Honey Balls	Pineapple
Bananas, lb.	Honeydew Melons	Plums
Blackberries	Lemons, Red Ball	Prunes
Blueberries	Lemons, Other Varieties	Quinces
Cantaloupe	Limes	Raspberries, Red
Cherries, Red	Nectarines	Raspberries, Black
Cherries, White	Oranges, Red Ball	Rhubarb
Cranberries, 25-lb. box	Oranges, Other Varieties	Strawberries
Gooseberries	Oranges, Valencia	Tangerines
	Peaches	Watermelons

Vegetables

Artichokes	Celery Hearts	Onions, 50 lbs.
Asparagus	Celery Cabbage, lb.	Okra, lb.
Beans, Green	Chard, Swiss	Oyster Plant, doz.
Beans, Lima	Cucumbers, bu.	Parsnips
Beans, Wax	Corn	Peppers, Green
Beets	Egg Plant	Parsley
Broccoli, 40 lbs.	Endive, doz.	Peas, Green
Br. Sprouts, 40 lbs.	Greens	Potatoes, Irish
Cabbage, Green	Kale	Potatoes, Sweet
Cabbage, Red	Kohlrabi	Pumpkin
Carrots, 50-lb. sack	Lettuce, leaf, bu.	Radishes
Cauliflower, 12	Lettuce, Head, 4 doz.	Rutabagas, 50 lbs.
Celery, 3½-4 doz.	Lettuce, Head, 6 doz.	Spinach, bu.
Celery Roots, doz.	Mushrooms, lb.	Squash, Hubbard
	Mustard, bu.	Squash, Summer
		Tomatoes
		Turnips
		Watercress

On the list on which quotations are to be noted, room is left for inserting additional information as to the different items. A copy of the prices, checked, is given to the storekeeper, with special notations as to the kind of oranges to be bought for juice or table, different brands of potatoes for baking or other purposes. The storekeeper visits the markets twice weekly, and reports any unusual market condition. He also inspects all goods received to see that they meet the specifications upon which prices were quoted.

This partnership arrangement has worked out well for both departments concerned. The dietitian gets the information she needs and is able to ask in advance for the qualities wanted, while the actual placing of orders is done by the same agency which receives the goods. With such a set-up, we believe that we have at least partially solved the problem of getting the "best of what we buy."

The second major consideration in our food control is the real food consumption, which is dependent upon menu planning, preparation and service. We believe that the problem is best approached by studying the food waste. If we know what foods are refused, we can find the reason, whether it is due to too large servings, personal dislikes or other causes. It may be the selection of foods, their mode of preparation, or some fault in the service. With this in mind, we have instituted several means of obtaining the desired information. The gross waste is obtained by a record of the weight of garbage from each service division. This is tabulated daily, with a note as to any one food found much in evidence. This garbage weight includes both edible and inedible food waste. By means of constant watching, the figures have been reduced until the average in the past twelve months has been 0.65 pounds of garbage per person per day.

In addition to the total figures for garbage, we have a check system of the foods for both the patients and the personnel. In the case of the former, student dietitians interview individual patients during the meal hour, and write a brief summary of comments which have been made. For example, reports such as this are not uncommon: "The meal was well liked except for the creamed carrots, which several said they never ate." And on a later report: "Carrot raisin salad found favor — none left on plates."

Not only is this personal contact a valuable indication for meal planning, but we find that the patient who feels someone is interested in his case is likely to make more of an effort to "leave a clean plate," and will often taste foods which are new to him just to please the dietitian.

As a check of the food served to the personnel, a book is kept by the dining room supervisor, in

See RESULTS of 3 years of NEW RESEARCH on Prunes

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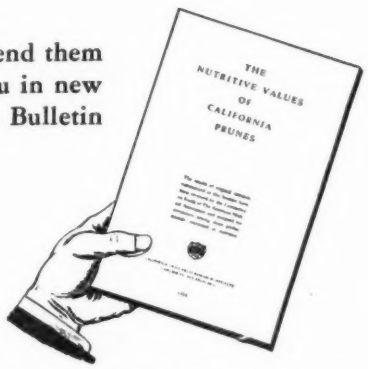
We send them to you in new FREE Bulletin



Have you the very latest information about the nutritive values of prunes—Science's new discovery in foods? And are you aware of the wide variety of economical recipes now made possible with this delicious fruit?

As a result of a three-year program of scientific laboratory tests conducted in several American universities, California Prunes are now revealed as a source of heretofore unknown food values. (See column at right.)

Accepted by Medical Association

A summary of this research, accepted by the Committee on Foods of the American Medical Association, is contained in a bulletin just published, "The Nutritive Values of California Prunes."

We will send this bulletin free on request to nurses, doctors, dietitians, and others connected in a professional capacity with recognized institutions. Just fill in the coupon below, mail it and this material will be forwarded by return mail.

4 New Aids to Dietitians

Also of interest to hospital dietitians, stewards, supervisors and others having to do with the planning of patients' meals, is the following material:

We Offer These Free Booklets:

1. *The Nutritive Values of California Prunes:* Complete and authoritative bulletin reporting the experiments and results of the recent scientific research on California Prunes.
2. *Prune Diet Manual:* Information on new and wider uses of prunes in the diet based on the recently discovered nutritional values of prunes.
3. *Prune Quantity Recipes:* Accurate directions for preparing prune recipes for multiple servings economically planned. Of particular interest to hospital stewards and attendants.
4. *Prunes Add Variety:* Twenty-nine new and attractive individual prune recipes, ten beautifully illustrated.

We will send any or all of these booklets free. Indicate in the coupon the material you wish to receive and it will be forwarded immediately. Meanwhile try the suggested recipe shown below. You will be amazed at the deliciousness added to this popular Prune Caramel Rice Pudding by the rich flavor of tender California Prunes.

Prune Caramel Rice Pudding

(Serves 100)

3¾ quarts uncooked prunes
7½ quarts cooked rice
2½ quarts granulated sugar
5 quarts water
3⅓ dozen eggs, beaten
1¼ cups butter
5 teaspoons salt
7 tablespoons vanilla

Boil prunes 20 minutes in sufficient water to cover; drain, cut from pits and put through food chopper, using medium knife. Combine sugar and 2½ quarts water in a kettle and boil until a golden brown; add remaining 2½ quarts water, boil until sugar is dissolved, and pour slowly over beaten eggs, beating continuously. Add butter, prunes, rice, salt, vanilla and blend thoroughly. Pour into baking dishes or casseroles and bake in a moderate oven (375 degrees F.) 50 minutes or until set. Stir once after baking 20 minutes. Serve with cream.

HERE IS SUMMARY OF THE MOST RECENT RESEARCH ON CALIFORNIA PRUNES

1. PRUNES NOW KNOWN TO CONTAIN AN ACTIVE LAXATIVE AGENT *in addition to* THE SMOOTH BULK THEY PROVIDE. No other fruit or food, including all those supplying roughage, is now known to possess the principle present in California Prunes. This makes them doubly effective in stimulating intestinal action.

2. PRUNES DO NOT AFFECT THE ALKALI RESERVE OF THE BLOOD. As much as 200 grams (18 prunes) per day in the usual diet does not significantly affect either CO_2 combining power of blood plasma or hydrogen ion concentration of the urine. The potential alkalinity of the ash of prunes is 24.4 (cc. normal acid per 100 grams of prune flesh).

3. PRUNES CONTAIN IMPORTANT VITAMINS IN SIGNIFICANT QUANTITIES. California Prunes (as sold) are an excellent source of vitamin A (500 Sherman units per ounce of flesh); good source of vitamin B (22 Sherman units); and an excellent source of vitamin G (80 Sherman units).

4. PRUNES CONTAIN ESSENTIAL MINERALS. Considerable amounts of mineral elements are contained in California Prunes, including calcium, potassium, phosphorus, sodium, iron, magnesium, manganese, copper, chlorine and sulphur.

5. PRUNES ARE RICH IN IRON AND COPPER. It has been determined (according to controlled animal study) that prunes are among the outstanding fruits highest in iron and copper content and are acquiring increasing importance in the dietary because of these two valuable elements.

6. PRUNES HAVE HIGH ENERGY VALUE. California Prunes are an excellent source of quickly available food energy owing to their high content of assimilable sugars. These sugars, being monosaccharides, quickly provide food energy for relieving fatigue due to lack of energy food or to excessive demands upon stored energy.

(A bulletin "The Nutritive Values of California Prunes" describes the above program in greater detail. A copy will be gladly furnished on request. (See coupon.)

UNITED PRUNE GROWERS OF CALIFORNIA, DEPT. 2-MH-5, 343 Sansome Street, San Francisco, California

Please send me, free, the material listed below which I have checked:

[ ] Bulletin on The Nutritive Values of California Prunes.
[ ] New California Prune Diet Manual.
[ ] Booklet describing New Ways to Serve California Prunes.
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which the foods served at each meal are graded. There are two points considered: popularity, based on comments and requests for seconds, and waste left on plates; each of these points may be rated from + to + + + +. It is not infrequently that we find a marked preference for the inexpensive dishes over those which are more costly. Thus broccoli may rate no more than + + in popularity, with + or + + rating in waste, while the humble cabbage may show no waste and + + + in popularity.

With all the above information as a basis for meal planning, it is necessary to see that the proper amounts of food are prepared. With standardized recipes giving the exact amounts for 100, 250 or more persons, the dietitian has only to indicate the set of figures to be used by the cooks. No deviation from the recipe is allowed, and there can be no waste due to improper preparation when a tested recipe is used, in the correct amounts.

Labor Cost Is a Large Item

We have accumulated, from records kept on foods used, a table of comparative figures. Thus in ordering string beans for the menu, the dietitian may consult her file to find that 28 lbs. of fresh, 19 lbs. of frozen or 4 No. 10 cans will serve 100 persons. She can thus take advantage of the prices which have been obtained.

All of the points enumerated above have been helpful to us in adapting our food service to our needs and tastes. It is especially gratifying to be able to lower costs through cutting down waste, at the same time elevating the food standards.

After a careful survey of possible flaws in buying, planning and preparation, one must give attention to the factor of labor costs, a large item in the total cost of food service. In any department or organization which has existed for a period of years, there are likely to be found persons who have practically pensioned themselves while still technically on duty. It is sometimes difficult to say the exact place in which slacking begins, and we have found a grade card helpful in pointing out weak spots. There are nine points on which the employee is graded, with a range of "A" to "D": appearance, personality, health, cooperation, obedience to orders, initiative, interest, technical skill and carefulness. The supervisor may then go over the record with the employee at the end of the month, pointing out the qualities in which he is falling below standard, and giving due credit for those in which he has shown excellence. Such a record plainly discloses whether the individual is willing to make an effort to improve, or whether his work remains consistently of a low grade. If he cannot or will not improve, he should be replaced.

We believe that best results are obtained by explaining the financial situation to employees, and asking for their cooperation in reducing the pay roll. It may be arranged for each kitchen employee to take a short leave of absence without pay, thus lowering the total pay roll over a period of time. This is accomplished with less resentment when the workers understand that a reduction must be made, and that each one is being asked to do his part. On one occasion, a kitchen helper quit just at the time when it seemed possible we would have to make a general wage cut. In this case, an explanation was made to the remaining employees, who agreed to divide the duties of that particular job among themselves, thus avoiding the general reduction.

For our own information, we run two-day time studies at intervals throughout the year. The exact times at which the employee starts and finishes his work are recorded, with the result that we may find one employee working overtime while another finishes early. In such cases, a more equitable division of labor can be made, or it may be found that a half-time employee can handle the work.

For our purposes, we have found these things helpful, namely, the efficiency record, the time study, and the cooperation of the working force.

There are doubtless many different problems which would arise in other dietary departments in connection with the three main factors of buying, preparation and labor. It is our belief that in any organization, no matter how strong, there are some weak points which are overlooked because of familiarity. A practice which has been followed for years may have been initiated to fit conditions entirely dissimilar to those of the present time. Whatever the situation, emphasis may safely be placed upon two methods of attack: first, close scrutiny of all details; second, significant records which are read and used.

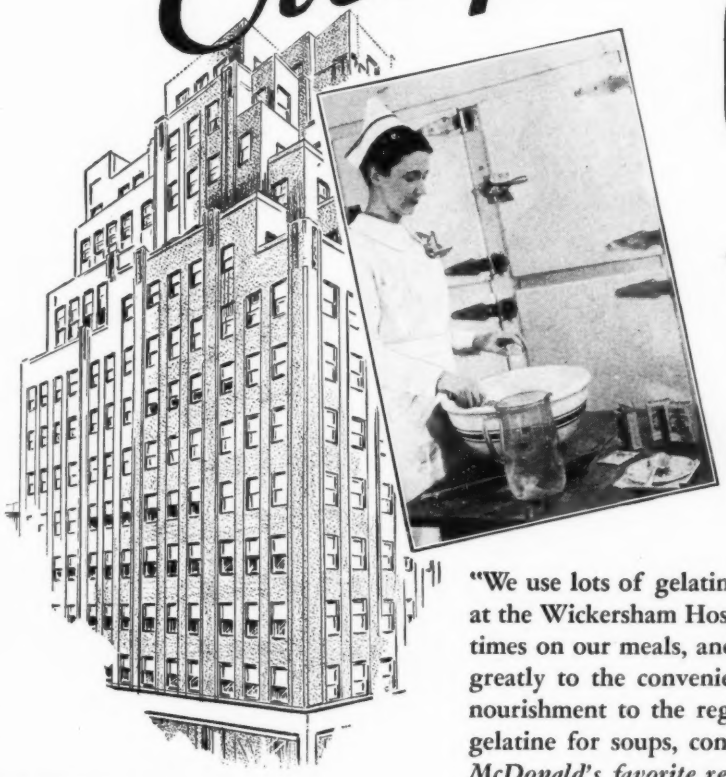
A Wholesale Price Increase Yardstick

The representative of a wholesale bakery company recently submitted to the administrator of one of the large state hospitals the following memorandum of the various increases in wholesale prices his firm had experienced between November 1, 1933, and November 1, 1934.

The cost of all foodstuffs is rising rapidly as evidenced below:

Sugar	13%	Plastic Butter	58%
Flour	94%	Figs	23%
Corn Starch	40%	Cocoanut	17%
Corn Oil	49%	Spices (Cinnamon)	43%
Corn Syrup	70%	Cocoa Butter	32%
Butter	35%	Peanuts	49%
Lard	118%	Honey	29%
Eggs	36%	Condensed Milk	86%
Lard Vegetable Butter	32%	Rolled Oats	39%

The Everyday use of GELATINE at WICKERSHAM HOSPITAL



WICKERSHAM HOSPITAL
NEW YORK CITY

Miss Mary B. Cochrane
Dietitian

"We use lots of gelatine here," says Miss Helen McDonald, Superintendent at the Wickersham Hospital, New York. "We have been complimented many times on our meals, and especially on our desserts. I find that gelatine adds greatly to the convenience of preparing meals and helps add variety and nourishment to the regular hospital dietary. I prefer the plain, unflavored gelatine for soups, consommes, salads, and desserts." *Here is one of Miss McDonald's favorite recipes:*

CHOCOLATE BAVARIAN CREAM—Serving 80 people

1 Cup Plain Gelatine	1 Quart Boiling Water
3 Cups Sugar	1 Cup Melted Chocolate
3 Quarts Heavy Cream	Pinch of Salt
1 Quart Cold Water	Vanilla

Pour cold water in bowl and sprinkle gelatine on top of water. Add sugar, salt and boiling water and stir until dissolved. Cool. Melt chocolate. Whip cream in electric whipper to one-half consistency; add chocolate. Whip slightly. Add gelatine mixture and whip until stiff. Pour into large or individual molds that have been rinsed in cold water. Chill. When firm, unmold and top with toasted marshmallow and serve.

There is no finer gelatine made than Knox Gelatine for use in the diet of the sick. It is purer than U.S.P. requirements and contains no pathogenic, gas, or acid-forming bacteria. It is as carefully made and supervised as an ampule solution. Gelatine may be used freely in the diet of convalescent, post-operative, tubercular, and chronically ill patients, because it is one of the most easily assimilated forms of protein. Knox Gelatine contains no carbohydrate and makes an ideal diabetic dessert where the added sugar is to be controlled.

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Food Intake of Children

By MARIE V. KRAUSE and LOIS SCHULZ
Department of Home Economics, University of Chicago

A FOUR WEEKS' food survey was made on children in the Gertrude Dunn Hicks Memorial Hospital affiliated with the University of Chicago, to establish the average food intake of children in this orthopedic hospital when offered an abundance of food. The study consisted of two parts, a preliminary period of two weeks to familiarize the personnel with the methods employed and a final period of two weeks in which food actually consumed by patients was recorded. Records on individual food intake were kept only on seriously ill patients.[1]

The literature contains many studies on the food intake of children in institutions which are not applicable to our hospital conditions. However, we were especially interested in a report by Peterman and Hug in 1930 at the Milwaukee Children's Hospital, Milwaukee. These authors studied the food consumption of thirteen children, ranging in age from two to twelve years, in an orthopedic hospital. All food was weighed or measured for nine months to determine the food requirement of children with chronic diseases, particularly those having tuberculous bone lesions. Additional servings of food were usually available if desired. The carbohydrate, protein and fat content of all food eaten was calculated and total calories computed. The daily intake per patient averaged between 1,000 and 2,130 calories. The only patients showing satisfactory gains in weight were those receiving calories 46 per cent or more above their basal requirements based on "normal" surface area. The protein intake averaged between 12 and 14 per cent, the carbohydrate intake between 49 and 52, and the fat intake between 35 and 38 per cent of the total calories.

TABLE I—THE FOUNDATION DIET

	Total Grams	*Carbohydrate*	*Protein*	*Fat*	*Calcium*	*Phos.*	*Iron*
Milk.....	1,000	50	30	40	1.2000	0.9300	0.0024
Egg, one....	50	0	6	6	0.0335	0.0900	0.0015
Meat, lean..	50	0	13	8	0.0072	0.1347	0.0018
Tomato....	200	6	2	0	0.0220	0.0520	0.0008
Lettuce....	50	2	1	0	0.0215	0.0210	0.0004
Orange.....	100	10	1	0	0.0450	0.0210	0.0002
Peach (canned)..	100	20	1	0	0.0144	0.0216	0.0002
Total....	...	88	54	54	1.3436	1.2703	0.0073

This foundation is calculated to contain approximately 55 grams protein and 1,055 calories. The foundation is adjusted as necessary to fill diet prescriptions for individual requirements. A quart of milk allows a wide margin of safety for calcium. The fruits and vegetables recommended provide residue to produce normal bowel function. Minerals and vitamins are furnished in abundance in the foundation. Cereal, cereal products, bread and potato are added to furnish calories as needed.

The methods used in this survey in the Gertrude Dunn Hicks Memorial Hospital were described by Smith and Biltz and used by them to compare the as purchased and prepared food methods for determining the food intake of hospital patients. It was possible for one dietitian to supervise this entire study, thus eliminating some of the errors which may occur where many people are involved and responsibility is divided.

The dietitian in charge of the diets in this orthopedic hospital received diet prescriptions for all patients. A foundation diet calculated to meet the needs of the growing child was used as a basis for menu planning, and is shown in Table I. The diets were approximately 97 per cent "general." Special diets, whenever possible, were planned as modifications of the general house diets. Food needed for each division was requisitioned from the food service department of the Billings Hospital. During this study a daily record was kept of the kinds and amounts of food served to patients, as well as a record of all food refused. Inventory made at the beginning of the periods and at the end of each week took account of all food on hand. Staple supplies received from the hospital stores and

TABLE II—ESTIMATED AVERAGE INTAKE PER PATIENT PER DAY ON PREPARED FOOD BASIS

			Wasted		*Consumed*	
	Nutrients	*Supplied*	*Am't*	*Per Cent*	*Am't*	*Per Cent Distribution of Calories*
March 16-21	Calories	2,137	117	5	2,020	—
	Carbohydrate, grams.	252	12	5	240	48
	Protein, grams	73	6	8	67	13
	Fat, grams	93	5	5	88	39
March 22-29	Calories	2,219	92	4	2,127	—
	Carbohydrate, grams.	258	11	4	247	47
	Protein, grams	74	3	4	71	13
	Fat, grams	99	4	4	95	40
Average	Calories	2,193	113	5	2,080	—
	Carbohydrate, grams.	256	12	5	244	47
	Protein, grams	74	5	7	69	13
	Fat, grams	97	5	5	92	40

[1]The food survey described was done under the supervision of Florence H. Smith, department of medicine, University of Chicago.

FOR THOSE WHO PREFER A DRY CARBOHYDRATE FOR INFANT FEEDING

"Karo Powdered"

PHYSICIANS have discovered for themselves the advantages of *Karo Syrup* for infant feeding, but some prefer a dry preparation to a syrup. To meet this demand, *Karo Powdered* has been developed . . . *Karo Powdered* is a pure granular mixture of dextrin, maltose and dextrose in suitable proportions for infant feeding. Marketed in dust-proof containers . . . Write for sample, booklet, and prescription blanks on *Karo Powdered.*

The 'Accepted' Seal denotes that Karo and advertisements for it are acceptable to the Committee on Foods of the American Medical Association

CORN PRODUCTS REFINING COMPANY
17 BATTERY PLACE ~ NEW YORK CITY

TABLE III—ESTIMATED AVERAGE INTAKE PER PATIENT PER DAY BY HOSPITAL DIVISION (14-DAY PERIOD BY ACTUAL CENSUS)

	Nutrients	Supplied	Wasted Am't	Wasted Per Cent	Consumed Am't	Consumed Per Cent Distribution of Calories
Group 1	Calories	1,938	109	6	1,829	—
	Carbohydrate, grams.	228	13	6	215	47
	Protein, grams	63	3	5	60	13
	Fat, grams	86	5	6	81	40
Group 2	Calories	2,093	151	7	1,942	—
	Carbohydrate, grams.	258	17	7	241	50
	Protein, grams	74	5	7	69	14
	Fat, grams	85	7	8	78	36
Group 3	Calories	2,449	38	2	2,411	—
	Carbohydrate, grams.	278	4	1	274	46
	Protein, grams	80	1	1	79	13
	Fat, grams	113	2	2	111	41

foods received by patients as gifts were added to the inventory. Deduction of the amount of food on hand at the end of the final week was made.

This weekly inventory allowed a division into weeks of the total food supply actually used, as well as a daily average. During this time a record was kept of the actual number of meals served each day. This figure was used for our calculations rather than the number of patients as shown by hospital census. The ages of the children receiving meals were also recorded.

The data for the study were collected after a two weeks' preliminary period. The menus were planned for a seven-day period. During the final study the menus were repeated for two consecutive weeks to eliminate as much as possible variations in intake due to individual preferences for certain foods. We also wished to test the accuracy of the so-called standard recipes used in the general kitchen. Past experience led us to believe that workers in a hospital kitchen, as do workers in a home kitchen, use materials on hand to the best advantage regardless of the so-called standard recipes. For this reason we were prepared to calculate the recipes actually used as well as the standard recipes. The food value of each recipe used was calculated each week. A wide variation was found in the ingredients used in the recipes when repeated, thus rendering it necessary to recalculate the food value of the total recipe and the single portion each time the recipe was used. In all, a total of 167 recipes were calculated in two weeks.

The average intake per patient per day (Table II) was fairly constant for each of the two weekly periods with an average intake of 2,080 calories per day. This was furnished by 244 grams of carbohydrate, 69 grams of protein and 92 grams of fat, with a percentage distribution of calories as carbohydrate 47, protein 13, and fat 40. The plate waste was rather uniform with an average of 5 per cent, which was lower than Biltz' figure for adults (12 per cent). This may be explained by the fact that many of these children had been hospitalized for a long period of time and were thoroughly adjusted to their environment.

Accurate records were kept by the dietitian of the age of the children and the number of diets served daily in each age group. With these data and the estimated standard normal diet for the age (Table IV) it was possible to calculate what the average daily intake for a similar group of so-called normal children would be. Comparisons with Table IV show these children at bed rest, or at most enjoying limited activity, actually receiving within 10 per cent of the calorie intake of the normally active child, with the percentage distribution of protein and carbohydrate calories as in the case of well children.

In Table III is shown the average food intake per patient per day by hospital divisions. This is included for comparing division intake with the average daily intake (Table II). Group I included a division for children of all ages who having just been admitted to the hospital had not become adjusted to this environment; it also included a division for infants and very young children whose total energy requirement was small. The total calorie intake per day was lowest in this group for these reasons. Group I consumed a daily average

TABLE IV—AVERAGE FOOD INTAKE PER PATIENT PER DAY AS CALCULATED FROM STANDARDS BY HOLT AND FALES*

Diets	Total Number Patient Days	Average Intake per Age Group: Calories	Carbohydrate	Protein	Fat
Age 1 week	14	428	54	17	16
Age 3½ mo	14	682	103	18	22
Age 9-12 mo	8	945	118	44	33
Age 2 years	65⅔	1,123	140	53	39
Age 3 years	47	1,256	157	58	44
Age 4 years	25	1,337	168	56	49
Age 5 years	81⅓	1,450	181	60	54
Age 6 years	70	1,560	195	60	60
Age 7 years	84	1,705	213	67	65
Age 8 years	17⅔	1,869	234	78	69
Age 9 years	52	2,046	256	80	78
Age 10 years	58	2,272	283	96	84
Age 11 years	102	2,512	314	80	104
Age 12 years	49	2,801	350	78	121
Age 13 years	66⅓	3,129	391	74	141
Age 14 years	106⅔	3,365	421	130	129
Age 15 years	41	3,543	443	130	139
Age 16 years	33⅓	3,626	453	116	150
Age 17 years	14	3,499	438	115	143
Age 20 years	4	3,334	417	115	134
Total for 14 days	880	2,013,402	251,907	71,907	79,794
Daily average		2,287	286	81	91

*Calculated from the given protein and assuming 50 per cent of the total calories were furnished by carbohydrate.

Facts WHICH TELL YOU A VIVID STORY ABOUT RALSTON

Figures, they say, speak louder than words. So we ask you to hear the tale these figures tell. A glance at the chart will tell you that Ralston Wheat Cereal, enriched with extra vitamin B—is consistently high in essential nutritive values—much richer in vitamin B than other commonly used cereals.

	% Protein	% Fat	% Carbohydrates	% Ash	% Calcium	% Phosphorus	% Iron	Calories per lb.	Vitamin B, Sherman Units per lb.
Ralston	14.5	2.20	72.0	1.6	.04	.37	.006	1800	900
Wheat flakes	13.0	1.4	74.0	2.2	.05	.37	.005	1600	Destroyed by toasting
Farina	11.0	1.4	76.0	0.4	.02	.13	.0008	1600	Too little to measure
Corn flakes	8.0	.4	87.0	3.0	.02	.12	.0009	1700	Destroyed by toasting
Rolled oats	16.0	6.0	68.0	1.9	.06	.42	.004	1800	200
Rice, white	8.0	0.3	79.0	0.4	.01	.10	.0009	1600	None

But that's not all!

Aside from its unquestioned value as a wholesome, nourishing food, Ralston has the extra advantage of tempting, delicious flavor. Children and grown-ups *enjoy* eating this hearty "double-rich" cereal regularly. Mothers appreciate your recommending Ralston because it cooks quickly—costs less than one cent a serving! For Laboratory Research Report and samples of "double-rich" Ralston Wheat Cereal use the coupon below.

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of 1,829 calories. This was furnished by 215 grams of carbohydrate, 60 grams of protein and 81 grams of fat, with a percentage distribution of calories as carbohydrate 47, protein 13 and fat 40.

Group II was made up of young children, patients who had recently been operated on and the very ill. Children in this group usually remained on the division for a few days or weeks only. The intake of food was higher than for Group I because the children were older. Group II consumed a daily average of 1,942 calories. This was furnished by 241 grams of carbohydrate, 69 grams of protein and 78 grams of fat, with the percentage distribution of calories as carbohydrate 50, protein 14 and fat 36. Here the percentage of waste was highest. This may have been caused by the fickle appetite of the very ill child and also because many of the children did not remain long enough to learn food habits as taught to Group III where the children were older and remained on the division for months or years, thus becoming adjusted to their environment.

Children in Group III consumed a daily average of 2,411 calories. This was furnished by 274 grams of carbohydrate, 79 grams of protein and 111 grams of fat, with a percentage distribution of carbohydrate 46, protein 13 and fat 41. An abundance of food was offered to all children and an examination of their weight charts showed satisfactory gains in body weight.

The total average food intake of the children in the Gertrude Dunn Hicks Memorial Hospital agreed with the accepted normal intake for well children of the same age within 10 per cent. Reliance must be placed on the foundation diet for further check on the adequacy of the diet, as this method of calculating food intake on the prepared food basis does not yield data which show the types of food furnishing the different nutrients. Neither does it allow estimates of the mineral and vitamin intake. The percentage of protein from animal and vegetable sources is not available by this method. The weekly calculation of recipes was necessary and time consuming.

Individual food intake of children in hospitals will vary widely. At the time this study was made records of the individual food intakes of sick children only were kept. The weight change in well children was used as an indication of adequate food intake.

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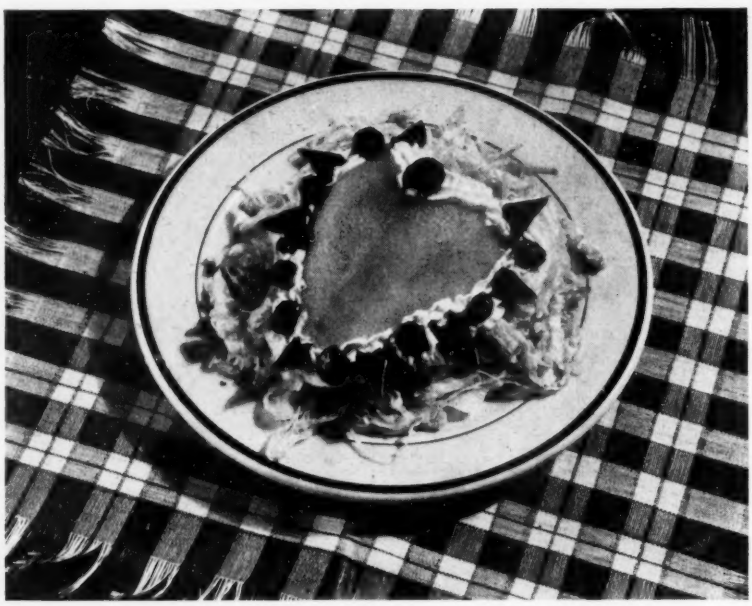
No. 8—Valentine Salad

By Arnold Shircliffe*



Lettuce
Pear (canned)
Cream Cheese
Rubyettes
Green Pepper

ON A BASE of lettuce place a half canned pear. Around the edge of the pear pipe a border of cream cheese in the form of a heart. Decorate the top of cheese with rubyettes and hearts cut out of green pepper. Serve with Lorenzo dressing. (See December issue, page 106.)

This is a colorful salad and very fitting for St. Valentine's Day celebration. It is truly a sweetheart. Red for love, white for purity and green for jealousy — all valentines have a little of all three ingredients wrapped up in their soul. The salad lacks the ingredients as well as the soul, but really has the colors.

*Author of Edgewater Beach Salad Book.

Poison on Foods

Large quantities of poisonous residues remain on fruits and vegetables as a result of spraying to combat insect pests, according to W. G. Campbell, U. S. Department of Agriculture. Extensive samplings indicate that effective washing equipment has not been developed to remove this health hazard. Consequently, those who supervise the preparation of raw foods must use every precaution.

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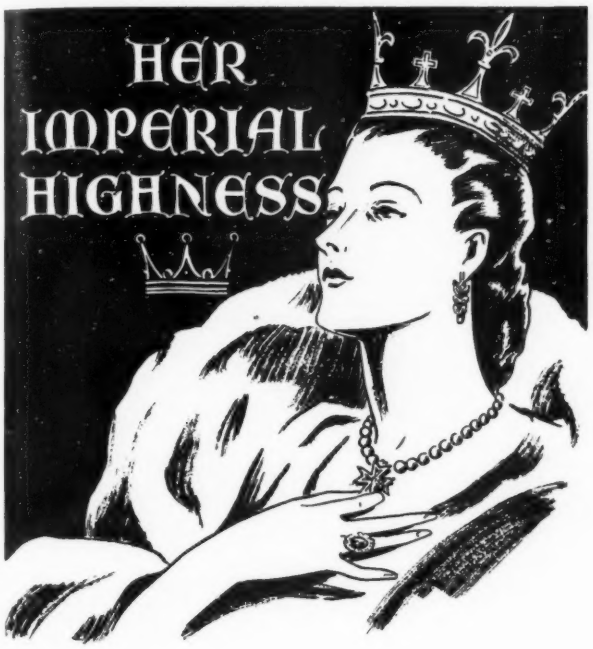
March Breakfast and Supper Menus*

By GRACE BULMAN
Superintendent of Dietitians, Veterans' Administration, Washington, D. C.

	BREAKFAST		SUPPER				
Day	*Fruit*	*Main Dish*	*Soup*	*Main Dish*	*Potatoes or Substitute*	*Vegetable or Salad*	*Dessert*
1.	Sliced Bananas	Bacon and Scrambled Eggs	Scotch Broth	Meat Pie	French Fried Sweet Potatoes	Waldorf Salad	Rice Custard
2.	Orange Juice	Poached Eggs	Corn Chowder	Salmon Croquettes, Cream Sauce	Duchess Potatoes	Cabbage and Pineapple Salad	Lemon Layer Cake
3.	Figs in Syrup	Creamed Dried Beef	Cream of Green Bean	Cheese Soufflé, Jelly	Country Fried Potatoes	Tomato and Lettuce Salad	Frosted Cup Cakes
4.	Grapefruit	Broiled Link Sausage	Giblet	Mixed Cold Cuts	Escalloped Potatoes	Cranberry Aspic	Fruit Gelatin, Custard Sauce
5.	Applesauce	Bacon and Fried Eggs	Bean	Ham and Potato Balls	Southern Spoon Bread	Pineapple and Cheese Salad	Coconut Cream Pie
6.	Tangerines	Codfish Balls	Beef Broth With Celery	Brunswick Stew	Buttered Rice	Stuffed Date Salad	Chocolate Layer Cake
7.	Pineapple Juice	Scrambled Eggs and Brains	Cream of Carrot	Lamb Chops	Stuffed Baked Potatoes	Lettuce With Chow Chow Dressing	Cinnamon Apples
8.	Orange Slices	Broiled Bacon	Mixed Vegetable	Hamburger Patties	Hashed Brown Potatoes	Coleslaw	Devil's Food Cake
9.	Stewed Prunes	Shirred Eggs	Clam Chowder	Nut Croquettes, Tomato Sauce	Julienne Potatoes	Buttered Spinach	Fruit Cup, Oatmeal Cookies
10.	Seedless Grapes	Sausage Patties	Cream of Pea	Broiled Liver and Bacon	Creamed Potatoes	Celery Hearts	Bread and Raisin Pudding
11.	Grapefruit	Frizzled Beef	Potato	Ham Omelet	Baked Lima Beans	Apricot Nut Salad	Cream Puffs
12.	Baked Apple	Bacon and Fried Eggs	Lamb Broth With Rice	Pork Chops	Franconia Potatoes	Red Cabbage Relish	Pineapple Tapioca
13.	Sliced Bananas	Soft Cooked Eggs	Cream of Tomato	Meat Loaf, Mushroom Sauce	Buttered Peas	German Potato Salad	Lime Snow, Custard Sauce
14.	Italian Plums in Syrup	Broiled Ham	Creole	Welsh Rabbit on Toast	French Fried Potatoes	Mixed Fruit Salad	Fig Nut Bars
15.	Orange Slices	French Omelet	Chicken and Vermicelli	Grilled Tongue With Banana Fritters	Saratoga Chips	Green Pepper and Cheese Salad	Peach Mousse
16.	Tomato Juice	Kippered Herring	Vegetable Chowder	Fried Scallops, Tartar Sauce	Baked Potatoes	Lettuce With French Dressing	Lemon Layer Cake
17.	Seedless Grapes	Kidney Stew	Cream of Spinach	Irish Stew With Vegetables		Buttered Green Beans	Green Gage Plums in Syrup, Almond Cup Cakes
18.	Tangerines	Bacon and Eggs	Beef Broth With Noodles	Creamed Dice Ham on Toast	Parsley Potatoes	Apple and Raisin Salad	Spice Cake With Chocolate Icing
19.	Orange Juice	Creamed Eggs and Scrapple	Russian Cream of Beet	Lima Beans With Bacon	Corn Fritters	Endive and Water Cress, Cheese Dressing	Individual Berry Pie
20.	Grapefruit	Canadian Bacon	Lentil	Creamed Eggs and Peas in Patty Shells	Cottage Fried Potatoes	Jellied Fruit and Gingerale Salad	Nut Macaroons
21.	Figs in Syrup	Ham Omelet	Tomato	Cold Sliced Lamb With Currant Jelly	Grilled Sweet Potatoes	Cream Cheese and Olive Salad	Cottage Pudding, Raisin Sauce
22.	Tokay Grapes	Scrambled Eggs and Dried Beef	Oxtail	American Chop Suey	Steamed Rice	Grapefruit and Apricot Salad	Ginger Cookies
23.	Sliced Bananas	Creamed Codfish	Vegetable Broth	Escalloped Oysters, Mushrooms	Julienne Potatoes	Green Pepper and Cabbage Relish	Brown Betty, Lemon Sauce
24.	Stewed Prunes	Shirred Eggs	Consommé With Celery	Veal Cutlets, Cream Gravy	Franconia Potatoes	Cherry and Grape Salad	Cream of Rice Pudding
25.	Pineapple Juice	Diced Ham in Cream	Cream of Corn	Mixed Grill	Escalloped Potatoes	Buttered Wax Beans	Plum Charlotte, Whipped Cream
26.	Applesauce	Broiled Bacon	Chicken and Rice	Macaroni au Gratin	Grilled Bananas	Deviled Egg Salad	Blackberries in Syrup, Mocha Cookies
27.	Orange Slices	Baked Hash With Poached Eggs	Okra	Vegetable Plate With Bacon	Lyonnaise Potatoes	Mixed Fruit Salad	Lemon Sponge Cake
28.	Stewed Apricots	Link Sausage	Cream of Asparagus	Veal and Peas en Casserole	Pan-Fried Potato Patties	Bread and Butter Pickles	Pears in Syrup, Wafers
29.	Tangerines	Baked Eggs	Onion	Creamed Chicken on Toast	Saratoga Chips	Stuffed Celery	Chocolate Ice Cream, Nut Cookies
30.	Tomato Juice	Broiled Trout	Split Pea	Grilled Shrimps	Duchess Potatoes	Beet Relish	Jam Tarts, Whipped Cream
31.	Grapefruit	Bacon and Eggs	Mock Turtle	Rice Croquettes, Cheese Sauce	Corn Pudding	Peach and Nut Salad	Currant Cake

*Cereals, breads and beverages are omitted from the breakfast menus because of space limitations. Recipes for any of the foregoing dishes will be supplied on request by Anna E. Boller, Central Free Dispensary, Rush Medical College, Chicago.



. . . the PATIENT

No matter how tenderly attentive the nurses and doctors, how attractive the surroundings, how tasty the food and drink, hospital patients are likely to complain with autocratic injustice. At no other time are they so sure to be despotic, ill-tempered and ungrateful.

Particularly is it difficult to please finicky coffee drinkers. That is why Continental developed special hospital coffees that will satisfy the most arbitrary coffee tastes. You can forget coffee worries with Continental's hospital blends now used in hospitals all over the mid-west.

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Why not make a trial of Continental and prove to yourself how satisfying it is. Disregard *our* four cup tests. Make one of *your own.* Just ask the Continental salesman who calls on you for samples, or write direct to Hospital Department 213.

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AMERICA'S LEADING FOUR CUP TEST

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Here is how Horlick's Malted Milk meets the requirements for the perfect contrast meal for gastro-intestinal diagnosis by X-ray:

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Horlick's effectively disguises taste of the barium sulphate. Affords definite amount of easily digested, suitably balanced food material.

2. Uniform Suspension
Horlick's colloidal constituents, notably the dextrins and gluten derived from malted cereals, and the albumin of the milk, make for uniform dispersion—a stable suspension, and shadow of even density.

3. Expulsion Time
Well within normal limits.

4. Penetration
The barium meal prepared with Horlick's penetrates every crevice of gastro-intestinal tract. Unlike meals which must be given cold to disguise degree of acidity, Horlick's may be given at body temperatures. Thus it will not disturb correct stomach motility, make diagnosis less certain.

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Does not over-stimulate or neutralize gastric secretions, for the partial pre-digestion of the food elements and the formation of an exceedingly fine curd give Horlick's a neutral quality in the alimentary tract.

6. Non-Constipating
Horlick's does not lump or constipate.

7. Non-Irritating
Neither burdensome nor irritating to diseased mucous membrane. Does not interfere with regular action of pylorus.

8. Definite Composition
By observing proportion of Horlick formulas, technician can be sure of solution uniform in character. Horlick's gives smooth, homogeneous suspension. Radiographs will be singularly free from defects attributable to character of suspension medium.

9. Convenient
Horlick's is easily and quickly prepared as needed. No waste. Either the natural or chocolate flavor of Horlick's may be used, according to patient's taste.

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NEWS OF THE MONTH

Eleven Insurance Principles Outlined by Economic Security Committee

Eleven general principles for a health insurance plan for the United States have been adopted by President Roosevelt's committee on economic security, according to the *Journal of the American Medical Association*. The full report of this committee is expected about March 1. The principles are as follows:

1. The fundamental goals of health insurance are: (a) the provision of adequate health and medical service to the insured population and their families; (b) the development of a system whereby people are enabled to budget the costs of wage loss and of medical costs; (c) the assurance of reasonably adequate remuneration to medical practitioners and institutions; (d) the development under professional auspices of new incentives for improvement in the quality of medical services.

2. In the administration of the services the medical professions should be accorded responsibility for the control of professional personnel and procedures and for the maintenance and improvement of the quality of service; practitioners should have broad freedom to engage in insurance practice, to accept or reject patients, and to choose the procedure of remuneration for their services; insured persons should have freedom to choose their physicians and institutions, and the insurance plan shall recognize the continuance of the private practice of medicine and of the allied professions.

3. Health insurance shall exclude commercial or any other intermediary agents between the insured population and the professional agencies which serve them.

4. The insurance benefits must be considered in two broad classes: (a) cash payments in partial replacement of wage loss due to sickness and for maternity cases, and (b) health and medical services.

5. The administration of cash payments should be designed along the same general lines as for unemployment insurance and, so far as may be practical, should be linked with the administration of unemployment benefits.

6. The administration of health and medical services should be designed on a statewide basis, under a federal law of a permissive character. The administrative provisions should be adapted to agricultural and sparsely settled areas as well as to industrial sections, through the use of alternative procedures in raising the funds and furnishing the services.

7. The costs of cash payments to serve in partial replacement of wage loss are estimated as from 1 to 1.5 per cent of pay roll.

8. The costs of health and medical services, under health insurance, for the employed population with family earnings up to $3,000 a year, is not primarily a problem of finding new funds but of budgeting present expenditures, so that each family or worker carries an average risk rather than an uncertain risk. The population to be covered is accustomed to expend, on the average, about 4.5 per cent of its income for medical care.

9. Existing health and medical services provided by public funds for certain diseases or for entire populations should be correlated with the services required under the contributory plan of health insurance.

10. Health and medical services for persons without income, now mainly provided by public funds, could be absorbed into a contributory insurance system through the payment by relief or other public agencies of adjusted contributions for these classes.

11. The rôle of the federal government is conceived to be principally (a) to establish minimum standards for health insurance practice and (b) to provide subsidies, grants or other financial aids or incentives to states which undertake the development of health insurance systems which meet the federal standards.

Hospital in Middle West Assumes "Nonprofit" Status

Stockholders of the West Suburban Hospital, Oak Park, Ill., have voted to transform the institution from a profit making to a nonprofit corporation, according to the *Chicago Tribune*. One of the principal motives for the change is the desire to obtain tax exemption for the hospital, according to spokesmen for the stockholders.

Under the reorganization plan, holders of $300,000 in preferred and $1,000,000 in common stock in the present hospital corporation will turn in their stock and receive in return low interest rate bonds of the new nonprofit corporation. The bonds do not carry the privilege of foreclosure for interest defaults.

The hospital was founded by a group of physicians who have controlled its business management as well as its professional direction. About 60 per cent of the stock is held by physicians.

"In at least one case," the *Tribune* says, "the transfer of a private hospital property to a nonprofit corporation has failed to win tax exemption. The Garfield Park Hospital underwent such a transformation in 1931, its stockholders receiving bonds for their equities. The assessor's staff refused it tax exemption for 1931 on the grounds that it was not a charitable institution, and the status of later years is still in litigation."

Joint Committee Drafts Letter for Legislators

The Joint Committee of the National Hospital Associations has sent hospitals all over the country the draft of a letter in the interests of hospitals with the request that each hospital forward copies of the letter to its legislators.

The purpose of the letter is to inform legislators of the precarious financial condition of hospitals and to secure the support of legislators in all matters that may arise affecting the ability of hospitals to protect the well-being of victims of the depression.

Hospitals are requested by the committee to send copies of the letter to the following legislators: to the two United States senators from the state in which the hospital is located; to the member of Congress from the hospital's congressional district, and to the members of the state legislature from the hospital's district or county.

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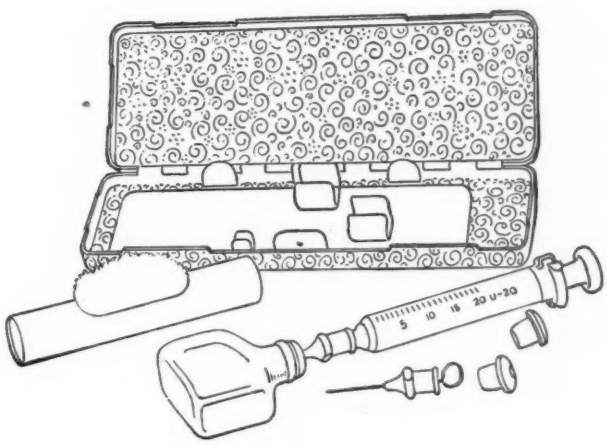

Diabetics will find Lilly's Ever-Aseptic Syringe Case, No. 65, a great convenience. Small in bulk, it contains an Insulin syringe, two needles, a metal cylinder for cotton, a sterilizing flask, and rubber stoppers. Once assembled, the syringe and needle are always ready for use. Supplied together with a package of cotton, four ounces of iso-propyl alcohol, and a glass pipette.

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Doctor Goldwater Plans Medical Research Council

Dr. S. S. Goldwater, commissioner of hospitals, New York City, announced recently that he would set up a medical research council to develop research activities in the city's hospital system.

The council, he explained, will be made up of department physicians and outside specialists. It will coordinate hospital department research work with that being carried on by the department of health. The council, he said, will be a semiofficial body, with the same relation to the department as that now held by the department's social service auxiliaries.

It is Doctor Goldwater's hope that when he has gathered a group of scientific leaders to back the research he can obtain contributions from individuals and philanthropic organizations for the support of full-time research men whose work would be coordinated with that of the hospital department's clinical and pathological staffs.

Oakland Housekeepers Receive Official Charter

The Oakland, Calif., chapter of the National Executive Housekeepers Association received its official charter recently at the conclusion of a dinner meeting held at the Leamington Hotel, Oakland. Alice M. Eldridge, Fairmount Hospital, Oakland, is president of the Oakland chapter. Nettie E. Kissack is secretary of the chapter.

A. C. Jensen, superintendent of Fairmont Hospital, was the principal speaker of the evening. Mr. Jensen emphasized in particular the importance of the hospital housekeeper.

Prof. I. S. Noall, University of California, is in charge of the educational program for the chapter. Classes are held every Friday evening.

Doctor Golub to Aid Jerusalem Medical Center

Dr. J. J. Golub, director, Hospital for Joint Diseases, New York City, and administrative consultant to the New York hospital department, will be consultant to the building committee of the first medical center to be erected in Palestine. The announcement to this effect was made recently by Mrs. Edward Jacobs, national president of Hadassah.

The new institution, which will be built on Mt. Scopus in Jerusalem, will be known as the Rothschild-Hadassah-University Hospital. Doctor Golub was in Palestine recently to help select a site for the new medical center.

A campaign to raise $300,000 for the building fund of the hospital is now in progress under the direction of Mrs. Moses P. Epstein, national vice president of Hadassah. At the beginning the units of the institution will include a model hospital of 250 beds, research laboratories and a nursing school.

Opens Roentgenotherapy Unit

A new roentgenotherapy department was dedicated recently at Hackley Hospital, Muskegon, Mich. The ceremony marked the thirtieth anniversary of the formal opening of the hospital. The principal speaker on the occasion was Dr. James T. Case, professor of radiology, Northwestern University School of Medicine, Chicago. Dr. Leland E. Holly, Muskegon, has been appointed head of the new department.

President Roosevelt Asks for Social Security Laws in Message to Congress

Unemployment insurance, work relief, old age benefits and annuities, increase in public health work, federal aid for the hospitalization and other care of crippled and handicapped children, for the care of homeless, neglected and delinquent children, and for child and maternal health services especially in rural areas were recommended to Congress and the nation by President Roosevelt and his committee on social security in the President's message to Congress delivered on January 17.

No recommendation regarding health insurance was included in the message as the medical, dental and hospital advisory committees had requested more time to work out their recommendations. Their report is due March 1. In discussing health service, however, the committee of cabinet members said "the second major step we believe to be the application of the principles of insurance to this problem."

The recommendations regarding unemployment insurance, which will probably affect hospitals as employers of labor, involves a federal tax of 1 per cent to 3 per cent of the pay roll, depending upon the speed with which business improves. After January 1, 1938, the tax would be 3 per cent of the pay roll regardless of business conditions in the country.

The states would be expected to administer the unemployment insurance and determine the amount of benefits and periods for which they would be payable.

Three different provisions for the aged are recommended:

1. Noncontributory old age pensions for those who are now old and have no means of support with the federal government paying one-half the cost to a maximum of $15 per week.

2. Compulsory contributory annuities for those who are now still young enough to work with a portion of the annuities for those who are past middle life being paid from government funds. The recommended rate of contribution is 1 per cent of the pay roll for the first five years, 2 per cent for the next five years and so on until a rate of 5 per cent is reached. These contributions are to be paid equally by the employers and the employees. Included would be all manual workers and all nonmanual workers who earn less than $250 a month.

3. A voluntary system of old age pensions sold to individuals at cost with a maximum annuity of $50 per month.

For children and mothers, the President and his committee recommended federal grants in aid for mothers' pension laws, the federal contribution to be one-third of the total.

In addition the committee recommended a nationwide preventive public health program with the federal government supporting the work of state and local governments by financial and technical aid.

Bills introduced into Congress carry $25,000,000 annually for aid to dependent children, $4,000,000 annually for maternal and child health work, $3,000,000 annually for care of crippled children, $1,500,000 annually for child welfare services and $10,000,000 for public health work.

The appropriation of $4,000,000,000 for a public works program which the President requested from Congress earlier is considered by administration spokesmen to be an integral part of the security program. The expectation is that the federal government through these various measures will so reduce the burden of straight-out relief that this can be turned over to the states and local areas and the federal government can retire from this field.

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Goldwater, in Report, Fears Damage to Service From Lack of Funds; Cheered by Year's Work

A troublesome period is impending for the Department of Hospitals of New York City, Dr S. S. Goldwater, commissioner, warns in his preliminary report to Mayor LaGuardia for 1934.

A long list of accomplishments during the year attests to Doctor Goldwater's satisfaction with the functioning of the department and the twenty-six institutions under its jurisdiction. He is concerned, however, about the financial problems looming on the horizon.

Doctor Goldwater lists three such problems. First, the perennial problem of inadequate funds for modernization, replacement and normal expansion. Second, the question of how to assume a larger share of the burden which private institutions are finding too heavy for them. Third, the demands, most of them meritorious, for increased remuneration for physicians, nurses and employees.

Cannot Match Private Hospitals

Regarding these three problems he states:

"Lack of funds has prevented the modernization and replacement of many inadequate and unsafe structures. With the limited funds at its disposal the department cannot match the most advanced private hospitals in plant, medical service, equipment, laboratory facilities or intensive nursing care.

"Lack of space has necessitated long delays in the admission of nonurgent but quite worthy hospital cases. Our failure to provide prompt treatment for thousands of children for whom tonsillectomies have been recommended has been warmly criticized. We cannot handle these cases promptly. Private hospitals can, and would if the cost were defrayed by the city or by any other agency.

"The present conduct of the department fails to satisfy a number of participating groups. Members of hospital staffs ask for a change in the city charter that will permit them to collect professional fees now paid into the city treasury in return for clinical services rendered under the Workmen's Compensation Law. Many physicians in our out-patient departments are no longer content to serve without pay and clamor for a change in the present system."

More than 247,000 patients and inmates were cared for during the year in the department's twenty-four hospitals and two city homes, the report says. Average bed occupancy was said to be 18,500, total days of institutional care 6,800,000 and total out-patient treatments of 500,000 patients 2,290,000.

A total of 80,000 "city" patients in private hospitals received 2,750,000 days of treatment. Visits to department hospitals by outside physicians and surgeons numbered 450,000. The services of the department were performed by 13,300 regular employees and 5,000 relief workers, of whom 2,000 were assigned to repair and maintenance work.

First on the list of accomplishments in the report is the banning of "department favors, formerly dispensed chiefly under political pressure," and the saving of more than $500,000 in the budget by the elimination of useless positions.

Other accomplishments reported are the improvement of the department's personnel and close observance of the merit system, "the humanizing of the Home for Dependents" following an investigation and dismissal of dishonest officials, improvement in purchasing methods, vigorous action against ambulance chasing and petty medical graft "with some success," formulation of plans for a chronic institution and convalescent park on Welfare Island and relieving "the worst dispensary conditions in the city" by construction of a temporary out-patient department for Harlem Hospital.

Minneapolis General Completes Annual Report

The annual report of Minneapolis General Hospital, Minneapolis, for the year 1933, consisting of three volumes containing a total of more than eight hundred pages, was completed recently.

The first volume is devoted to the administrator's didactic and statistical report with a miscellany supplement. The second volume covers departmental administrative divisions. The third volume is devoted to reports of departments responsible for the professional care of patients and for the hospital teaching program. The 1933 report, according to Dr. Charles E. Remy, superintendent of the hospital, "has been compiled and indexed with the idea that it may be utilized as a reference text on hospital procedures for comparison in relation to hospital figures."

This year, due to the high publication and mailing costs, copies of the report will not be sent to other hospitals. Copies are available, however, at $5 a set, which, it is stated, represents the cost of publication and distribution.

Skin and Cancer Clinic Opened in New York

Under the terms of the affiliation agreement effected last September by the boards of directors of Stuyvesant Square Hospital and New York Post-Graduate Medical School and Hospital, New York City, which consolidated the work of these two institutions, one of the largest and most completely equipped clinics for the treatment of cancer and skin diseases was opened January 21.

The new clinic occupies the entire four-story building which until recently housed both the in-patient and out-patient services of Stuyvesant Square Hospital. This building has been completely remodeled and equipped for dispensary service throughout.

Nursing Bureau Formed

The Official Nursing Bureau of Morris County, Inc., is the name of a new nursing bureau organized recently at Morristown, N. J. The object of the bureau is to provide adequate nursing service to the community, to have a central place where physicians may call for the type of service required, and where nurses may register. The bureau supplies registered nurses, practical attendants with and without training, male nurses and hourly nursing service. Its board of directors consists of nurses and its advisory committee of physicians and lay people.

New Tuberculosis Hospital

A new tuberculosis hospital which is to be erected soon in Lucas County, Ohio, is to be named for the late William W. Roche, who was for many years a political reporter on the Toledo *News-Bee*. Mr. Roche is credited with having instigated a reorganization of the county hospital about twenty years ago. The hospital is to be built as an FERA project.

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Gives Large Sum to Convalescent Home

The Toronto General Hospital, Toronto, Ont., is to receive a bequest of approximately $300,000 from the widow of the late Dr. George A. Bingham to build and maintain a home for convalescent patients as a memorial to him. Doctor Bingham, who died in 1922, was professor of clinical surgery and clinical anatomy at the University of Toronto Faculty of Medicine.

Mrs. Bingham's will, recently filed for probate, also gave $2,000 to the Hospital for Sick Children, $1,000 to the Home for Incurable Children, $25,000 for the equipment of a hospital at Matheson, Ont., and $5,000 to the Alumni Federation of the University of Toronto for needy students in the faculty of medicine.

St. Elizabeth's Improves and Adds Equipment

A number of improvements have been made at St. Elizabeth's Hospital, Baker, Ore., according to Sister Mary Patrick, superintendent of this 77-bed institution.

The floor of the main hall has been covered with new linoleum. The gas ranges and cooking utensils in the dietetic department have been refinished in aluminum and the entire department has been repainted with aluminum color paint. The floors have been finished in tan.

A new children's ward fitted with modern equipment has been opened on the main floor. A new telephone system and mechanical refrigerators have been installed throughout the building. The wards have been refinished in pleasing pastel shades and the main elevators have also been repainted. Several pieces of new equipment have been installed in the classrooms.

The main surgery has been improved by the installation of a new floor model operating light. The new light is shown in the accompanying photograph which was taken with the entire surgical staff in attendance during a bone operation.

Main surgery of St. Elizabeth's Hospital, Baker, Ore.

Elects New Officers

New officers were elected at a recent meeting of the Hospital Council of Kansas City, Kan., Kansas City, Mo., and Independence, Mo. Dr. H. R. Wahl, superintendent, Bell Memorial Hospital, Kansas City, Kan., is the new president of the council, and the secretary is Sister M. Pascaline, superintendent of St. Joseph's Hospital, Kansas City, Mo.

The council's committee on group hospitalization is busily engaged in preparing a set-up similar to that inaugurated recently in Cleveland. The committee will confer with the Jackson County Medical Society with a view to obtaining the cooperation of the medical profession in its plan to carry out group hospitalization.

Radium "Bomb" Installed in Chicago Hospital

A new radium "bomb" has been added to the equipment of the cancer clinic at the Veterans Administration Hospital, Hines, Ill. The bomb contains two grams of radium valued at $100,000. The opening of this new radium room gives the Chicago district two firstclass cancer clinics, the other being at Michael Reese Hospital.

The Veterans Administration clinic is headed by Dr. John W. Turner, assisted by Dr. A. E. Williams, chief radiologist. The clinic is used as a model by the American College of Surgeons to assist in organizing similar clinics.

The radium bombs at the Veterans Administration and Michael Reese Hospitals are of special construction. A balanced arm, which for want of a better name is termed "cannon" by the hospital authorities, carries the radium in one end and a counterweight in the other. The balance is so delicate that the slightest pressure allows the radium to be put to any position on a patient's body.

Nursing League Makes Study of Two Problems

The National League of Nursing Education is gathering information on two important matters regarding the nursing profession.

One questionnaire was sent out by the league early in January to accredited schools of nursing. When answers are returned and compiled, the league expects to have a real picture of what's what in the accredited schools of nursing, including, among other things, their size, entrance requirements, experience and service for students.

The second questionnaire, a salary study, is being perpetrated by the league in cooperation with the American Hospital Association. This questionnaire has been mailed to 500 hospital superintendents. In addition to data on salaries, information about vacations, illness and physical examination policies is being sought.

Remodels Old Building

The French Hospital, New York City, has started alterations on its nurses' home to convert the building into a maternity unit. For the present three floors will be used for beds, and one floor for operating rooms and delivery rooms. This space will provide accommodations for approximately fifty patients. Later the remaining floors will be similarly altered. The architects of the original hospital, Crow, Lewis and Wick, are in charge of the work, with Charles F. Neergaard, New York City, acting as consultant.

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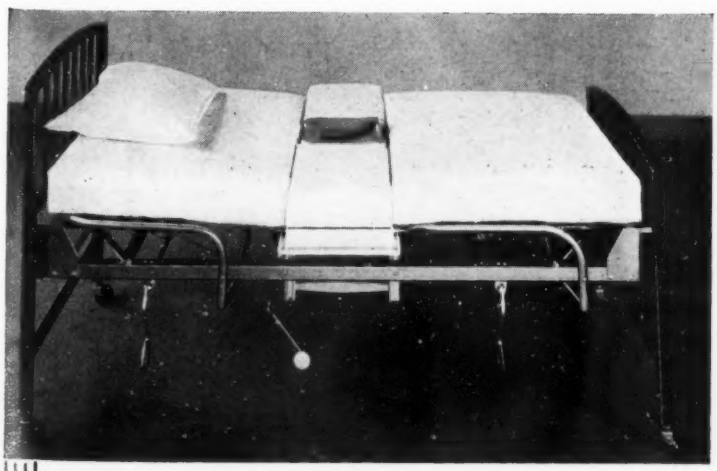

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Another Hospital Closes in New York City

Another voluntary hospital in New York City, St. Mary's Hospital for Children, Inc., has closed its doors for lack of funds. This was the second hospital to close in New York City during December. The other was the New York Nursery and Child's Hospital.

It was explained at the hospital that various causes contributed to the closing, all of them financial. Sister Hilary, superintendent of the institution, states that the hospital has received permission from the state board of social welfare to discontinue its work as an acute hospital for children and to reorganize some months hence as an institution for the care of convalescents.

St. Mary's Hospital was established in 1870 by the Sisters of St. Mary of the Protestant Episcopal Church.

Social Workers Name Secretary

Mary M. Maxwell has been appointed executive secretary of the American Association of Hospital Social Workers, Chicago, to succeed Helen Beckley who resigned last October 1 to become director of social service at Cook County Hospital, Chicago. Miss Maxwell, who will assume her new duties April 1, has served on various committees of the American Association of Medical Social Workers since 1930. She was formerly a case worker in the social service department of Massachusetts General Hospital, Boston, and later was director of the social service department at University of Iowa Hospital, Iowa City, Iowa.

New York Hospital Fund Nears Goal in Campaign

David H. McAlpin Pyle, reelected president of the United Hospital Fund of New York at the annual meeting of the corporation, held on January 14, announced that subscriptions and pledges in the fund's campaign for $500,000 for free care in its fifty-six member hospitals had reached nearly $400,000 on that date. The campaign for the full amount continues. Mr. Pyle stated that the condition of the voluntary hospitals from the standpoint of securing adequate financial support was the most critical in this generation.

Karl Eilers, chairman of the fund's committee on group insurance, reported on the steps which have been taken thus far to set up such a system in New York City whereby wage earners and small salaried persons will be able to defray the costs of hospital care on an insurance instead of a charity basis. Special funds from private sources are now being sought to launch the plan.

New Hospital Dedicated

The new Jewish General Hospital at Montreal, Que., was dedicated recently with appropriate ceremonies. The hospital, begun in 1932, was erected at a cost of approximately $1,250,000.

Surgeon General Reports on Nation's Health

There is yet no evidence that the depressed economic conditions of the past few years have lowered the general health of the people of the United States, according to the surgeon general of the United States Public Health Service. This information is presented in his annual health accounting to Congress which reports the activities of his organization for the 136th year of its existence.

While death rates are available from year to year as an index to health, the surgeon general has not relied upon these rates alone but has instituted special studies of actual sickness over a period of several years, beginning in 1929, in ten localities where the depression has been most severe. These studies show higher sickness rates in the economic group rated in comfortable circumstances in 1929 but subsequently reduced to the lower economic class. The most important reasons given for the continuation of general good health are the vast work of the relief agencies and the fortunate absence of widespread epidemics.

For the calendar year 1933 the general death rate, 10.5 per 1,000 population, was the lowest ever recorded in the United States; the rate for 1932 was next lowest, 10.8 per 1,000. While health conditions remained comparatively good for the first half of 1934, the death rates for many localities were higher than those for the preceding year.

Alterations to Office Quarters

Alterations to the administrative offices and the physicians' rooms at Good Samaritan Hospital, Portland, Ore., were started recently from plans prepared by Lawrence and Holford, architects. The cost will amount to approximately $9,000. Carolyn E. Davis is superintendent of the hospital.

Hospital Council of New York Formed: Private and City Institutions Will Cooperate

Coordination of the functions of city owned and private hospitals will be undertaken by the Hospital Council of New York, a new agency formed by Mayor LaGuardia at a meeting held January 18.

The council consists of the following twenty-eight members, representing philanthropic and welfare leaders, city officials, members of the New York Academy of Medicine and representatives of county medical societies:

New York Academy of Medicine—Dr. B. Sachs and Dr. John A. Hartwell; Queens County Medical Society—Dr. Charles Miller and Dr. Howard Neail; Medical Society of the County of New York—Dr. Franklin Welker, president; Kings County Medical Society—Dr. John Sturdivant Read, president, and Dr. Alec N. Thomson; Richmond County Medical Society—Dr. Arthur S. Driscoll and Dr. William C. Buntin; Federation for Support of Jewish Philanthropic Societies—Solomon Lowenstein, executive director, and Frederick M. Stein; Brooklyn Federation of Jewish Charities—Joseph J. Schwartz, executive director, and Joseph J. Baker; Controller of the City of New York—Frank J. Taylor and G. Harry Lynn; Commissioner of Health—John L. Rice and Dr. Herbert R. Edwards; Catholic Charities of the Archdiocese of New York—The Rev. Joseph S. O'Connell, director of division of health of Catholic charities; Catholic Charities Diocese of Brooklyn—Mgr. J. Jerome Reddy, director, and Father Brophy, director of hospital division; United Hospital Fund—David H. McAlpin Pyle, president, and Homer Wickenden; Welfare Council—C. C. Burlingham, president, Jane Hoey and Robert P. Lane; Commissioner of Hospitals—Dr. S. S. Goldwater; Bronx County Medical Society—Dr. Milton J. Goodfriend, president, Dr. David J. Kalish, chairman, Doctors' Coordinating Committee.

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Institute Celebrates Twenty-Fifth Anniversary

The twenty-fifth anniversary of the founding of the Neurological Institute of New York, now part of the Columbia-Presbyterian Medical Center, was celebrated on December 20 with colorful ceremonies at the institute.

Telegrams of congratulation commending the achievements of the institute and its pioneer work in the research and treatment of the diseases of the brain and the nervous system were received from President Roosevelt, Governor Lehman and other leaders in American life.

The principal speaker was Dr. Joseph Collins, the sole survivor of the three original founders of the institute. A silver tray was presented to him on behalf of the medical staff.

Razing of Hospital Started

Removel to temporary quarters of units at Memphis General Hospital, Memphis, Tenn., preparatory to demolition of the old building on Madison Avenue and construction of the city's new half-million dollar hospital was started early in January. J. F. Ward is superintendent of the hospital.

Pennsylvania Launches Big Legislative Program

The Hospital Association of Pennsylvania is planning an intensive public relations program for the period ahead. To guide this work properly the association has enlisted the services of Theodore Maisch, publicity expert, who will serve as public relations assistant to the executive secretary, John N. Hatfield of Philadelphia.

Public relations material will be prepared by the executive's office. Distribution will be accomplished through liaison officers throughout the state.

For the present the association's legislative program will receive the bulk of attention, due to the fact that several bills important to hospitals in the state, are to be presented at the forthcoming session of the state legislature.

One of these bills provides for allocating a portion of the present automobile registration fees or tax on gasoline for reimbursing hospitals for services rendered to indigent patients injured on the highways.

Several bills will be introduced to provide amendments to the state compensation act in order to eliminate the hardships that the present act places upon hospitals and physicians.

It is hoped to introduce a bill which will permit the state through its department of welfare to pay for the hospitalization of tuberculous patients who have been referred to general hospitals and accepted by general hospitals as such, at the established ward costs.

A bill will also be introduced seeking to amend the present state liquor act so that hospitals may purchase liquors at the wholesale rates now accorded clubs and hotels.

A bill will be introduced permitting cities, townships and boroughs to make appropriations to state-aided hospitals for services rendered to indigents of such cities, townships and boroughs.

The present state milk control act requires hospitals to purchase their milk under code restrictions the same as other users of milk. An effort will be made to secure passage of a bill exempting hospitals and other charitable institutions from the provisions of the milk code.

The legislative committee has recommended that state-aided hospitals should work for an appropriation above that granted in the last two bienniums in view of the fact that appropriations now made are based upon the free work done in the year 1930 — the start of the depression.

Coming Meetings

New England Hospital Association.
President, Albert W. Buck, New Haven Hospital, New Haven, Conn.
Secretary, Dr. Albert G. Engelbach, Massachusetts General Hospital, Boston.
Next meeting, Boston, Feb. 7-9.

National Methodist Hospitals and Homes Association.
President, Rev. Karl Meister, Elyria Home for the Aged, Elyria, Ohio.
Secretary, Guy M. Hanner, Beth-El Hospital, Colorado Springs, Colo.
Next meeting, Chicago, Feb. 13-14.

Congress of Council on Medical Education and Hospitals of American Medical Association.
Next meeting, Chicago, Feb. 18-19.

Western Hospital Association.
President, Dr. J. Rollin French, Golden State Hospital, Los Angeles.
Secretary, Lola M. Armstrong, *Western Hospital Review*, Los Angeles.
Next meeting, San Francisco, Feb. 18-21.

Hospital Association of Texas.
President, Bryce L. Twitty, Baylor Hospital, Dallas.
Secretary, May Smith, Bradford Memorial Hospital, Dallas.
Next meeting, Marlin, March 22-23.

Ohio Hospital Association.
President, John R. Mannix, University Hospitals, Cleveland.
Executive secretary, A. E. Hardgrove, City Hospital of Akron, Akron.
Next meeting, Columbus, April 2-4.

North Carolina Hospital Association.
President, Newton Fisher, James Walker Memorial Hospital, Wilmington.
Secretary-treasurer, M. E. Winston, Rex Hospital, Raleigh.
Next meeting, Greensboro, April 11-12.

Iowa Hospital Association.
President, Thomas P. Sharpnack, Broadlawns Hospital, Des Moines.
Secretary, Erwin C. Pohlman, University Hospitals, Iowa City.
Next meeting, Iowa City, April 29-30.

Joint Meeting Illinois, Indiana and Wisconsin Hospital Associations.
Chicago, May 1-3.

Hospital Association of Pennsylvania.
President, Charles A. Gill, Episcopal Hospital, Philadelphia.
Executive secretary, John N. Hatfield, Pennsylvania Hospital, Philadelphia.
Next meeting, Philadelphia, May 8-10.

Michigan Hospital Association.
President, Dr. Warren L. Babcock, Grace Hospital, Detroit.
Secretary, Robert G. Greve, University Hospital, Ann Arbor.
Next meeting, Jackson, May 9-10.

Mississippi Hospital Association.
President, Dr. R. J. Field, Field Memorial Hospital, Centreville.
Secretary, Dr. Leon S. Lippincott, Vicksburg Sanitarium, Vicksburg.
Next meeting, Biloxi, May 13.

Hospital Association of New York State.
President, P. Godfrey Savage, Niagara Falls Memorial Hospital, Niagara Falls.
Executive secretary, Carl P. Wright, General Hospital of Syracuse, Syracuse.
Next meeting, New York City, May 23-24.

Mid-West Hospital Association.
President, Frank J. Walter, St. Luke's Hospital, Denver.
Executive secretary, Walter J. Grolton, City Hospital No. 1, St. Louis.
Next meeting, Colorado Springs, Colo., June 6-7.

American Medical Association.
President, Dr. Walter L. Bierring, Des Moines, Iowa.
Secretary, Dr. Olin West, 535 North Dearborn Street, Chicago.
Next session, Atlantic City, N. J., June 10-14.

Canadian Medical Association.
President, Dr. J. S. McEachern, Calgary, Alta.
General secretary, Dr. T. C. Routley, 184 College Street, Toronto, Ont.
Next session, Atlantic City, N. J., June 10-14.

Minnesota Hospital Association.
President, J. H. Mitchell, Colonial Hospital, Rochester.
Executive secretary, A. M. Calvin, Midway and Mounds Park Hospitals, St. Paul.
Next meeting, Duluth, June 20-21.

Hospital Association of Nova Scotia and Prince Edward Island.
President, Rev. H. G. Wright, Inverness, Nova Scotia.
Secretary, Anne Slattery, Dalhousie University, Halifax, Nova Scotia.
Next meeting, Wolfville, Nova Scotia, June, 1935.

Missouri State Hospital Association.
President, Walter J. Grolton, City Hospital No. 1, St. Louis.
Next meeting, Colorado Springs, Colo., June, 1935.

American Protestant Hospital Association.
President, Dr. Charles C. Jarrell, 405 Wesley Memorial Building, Atlanta, Ga.
Executive secretary, E. E. Hanson, Lutheran Deaconess Home and Hospital, Chicago.
Next meeting, St. Louis, Sept. 27-30.

American Hospital Association.
President, Robert Jolly, Memorial Hospital, Houston, Tex.
Executive secretary, Dr. Bert W. Caldwell, 18 East Division Street, Chicago.
Next meeting, St. Louis, Sept. 30-Oct. 4.

American College of Surgeons.
President, Dr. Robert B. Greenough, Boston.
Director-general, Dr. Franklin H. Martin, 40 East Erie Street, Chicago.
Next meeting, San Francisco, Oct. 28-Nov. 1.

Association of Record Librarians of North America.
President, Edna K. Huffman, St. Luke's Hospital, Davenport, Iowa.
Corresponding secretary, Helen Hays, St. Alexis Hospital, Cleveland.
Next meeting, San Francisco, Oct. 28-Nov. 1.

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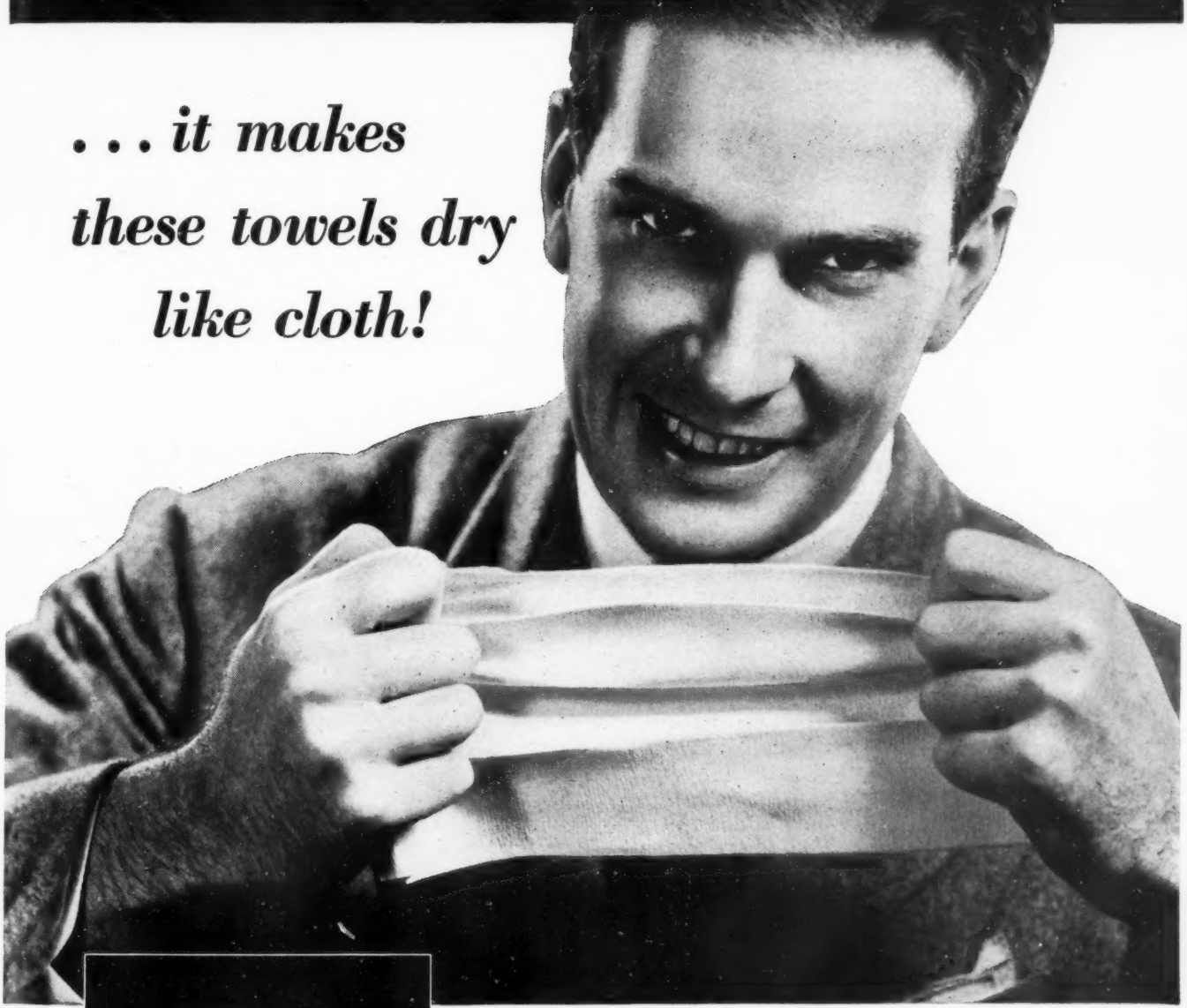
. . . it makes these towels dry like cloth!



● *A delightful towel, the new "soft-weve" ScotTissue. It's so smooth and soft, you'd think it were linen.*

BECAUSE IT *STRETCHES*, the new "soft-weve" ScotTissue Towel is more pliable. It wraps snugly around the knuckles, digs gently into the hollows of the hands and face. It is actually 20% more absorbent, and dries completely dry . . . *like cloth.*

And as for strength! The new "soft-weve" ScotTissue Towel, with its 50% greater stretch, has a toughness of fibre surprising in so soft a towel. It holds its shape *even when wet.*

Naturally, "soft-weve" ScotTissue reduces towel bills. For *one* towel usually does the job. Cost *per person, per drying,* goes way down.

In two minutes, in your own washroom, you can prove this "stretchy" towel a better towel. Write for our free trial packet. Scott Paper Co., Chester, Pa.

Soft-Weve Scot Tissue Towels

Your Hands are the First to Touch Them!

PERSONALS

W. MEZGER, assistant superintendent of Michael Reese Hospital, Chicago, has accepted the superintendency of Knickerbocker Hospital, New York City, succeeding LUCY M. MOORE, who died recently.

DR. B. F. SMITH, superintendent of Willmar State Asylum, Willmar, Minn., since 1927, has been appointed superintendent of Rochester State Hospital, Rochester, Minn., succeeding DR. ARTHUR F. KILBOURNE, who died recently. DR. S. R. LEE, who has been associated with the Hastings State Asylum, Hastings, Minn., has been named superintendent of Willmar State Asylum.

ADELAIDE F. BARTLETT, who was appointed several months ago to the superintendency of Wyoming Valley Homeopathic Medical and Surgical Hospital, Wilkes-Barre, Pa., has resigned to take up a branch of church work.

LOTTIE A. DARLING has resigned as superintendent of nurses and principal of the school of nursing at Allegheny General Hospital, Pittsburgh. The vacancy has been filled by the appointment of M. EVA DUNNE, superintendent of nurses at Buffalo General Hospital, Buffalo, N. Y., for the past ten years.

C. J. ROSS has been appointed acting superintendent of Stanford University Hospitals, San Francisco.

DR. JOSEPH I. BLUESTONE, whose recent death was reported from New York City, was one of the founders of Beth Israel Hospital, in that city. Doctor Bluestone served on the hospital's medical board and retired with the rank of emeritus attending physician. He was the father of DR. E. M. BLUESTONE, a member of the editorial board of The MODERN HOSPITAL.

KATHERINE A. SANBORN has retired as directress of the school of nursing at St. Vincent's Hospital, New York City, after serving in that position for forty-two years. Miss Sanborn was honored with a testimonial dinner preceding her retirement.

GRACE E. HAYCOCK has been named assistant superintendent and director of nursing service at Saratoga Hospital, Saratoga Springs, N. Y., succeeding RUTH A. WILES. For the last four years Miss Haycock has been assistant superintendent and director of nursing service at New York Nursery and Child's Hospital, New York City, which was closed recently.

DR. JOHN W. ODEN, superintendent of the Georgia Training School for Mental Defectives, Gracewood, Ga., has been named superintendent of Milledgeville State Hospital, Milledgeville, Ga., succeeding DR. ROGER C. SWINT, head of the institution for the past twenty-four years.

JANET G. GRANT has resigned as superintendent of Moses Taylor Hospital, Scranton, Pa. Miss Grant's retirement terminates thirty-five years of continuous service to the institution.

EVELYN PERKINS has been named acting superintendent of King's Daughters' Hospital, Portsmouth, Va.

FLORENCE SLOCUM has been appointed acting superintendent of Shriners' Hospital for Crippled Children, Spokane, Wash.

MARY P. BROWN for a number of years assistant superintendent of nurses at Mt. Sinai Hospital, New York City, has been appointed superintendent of nurses at Manhattan Eye, Ear and Throat Hospital, New York City, succeeding HELENA M. TOOTHAKER, who has retired on account of illness after twenty-six years of service to the institution.

ELIZABETH CRAVEN, Durham, N. C., has joined the staff of Tuomey Hospital, Sumter, S. C., as laboratory technician, succeeding the former ELLA DUNN, who was married recently to Dr. V. R. ELEAZER.

B. A. FRIBERG has been appointed superintendent of Swedish Baptist Home of Rest, Inc., Shelton, Conn.

CHARLES J. BRISLER is the new superintendent of Lutheran Home Finding Society of Illinois, Chicago.

ANNA HOLTMAN has been appointed superintendent of Christian Welfare Hospital, East St. Louis, Ill. Miss Holtman has been employed in the hospital for three and a half years, acting as superintendent of nurses and of the nursing school and remains in that capacity. REV. WALTER SCHLARETZKI, who has been superintendent for more than two years, has been appointed to the newly created position of general manager of the St. Clair Hospital Association which owns and operates the hospital.

VICTORIA SMITH has been appointed superintendent of Englewood Hospital, Englewood, N. J., succeeding JANE DURHAM. Miss Smith was previously superintendent of nurses at the hospital, which position she continues to fill.

DR. JOHN L. DAY, Norman, Okla., has been appointed superintendent of Western Oklahoma Hospital, Supply, Okla., succeeding the late DR. JAMES W. MCCLENDON.

DR. DAVID W. GRIFFIN, superintendent of Central Oklahoma State Hospital for Insane, Norman, Okla., was honored at a reception given by the hospital staff and other friends, recently, in celebration of his completion of thirty-five years at the head of the institution.

FRANCES M. KUHNS has been named superintendent of the Ladies of G. A. R. Home, Pittsburgh.

RICHARD B. CUTHBERT is the new superintendent of Methodist Episcopal Hospital and Home for Aged, Pittsburgh.

PERRY F. SNELL is the new superintendent of York County Home, York, Pa.

DR. HARRY J. WORTHING, first assistant physician at St. Lawrence State Hospital, Ogdensburg, N. Y., has been appointed superintendent of Willard State Hospital, Willard, N. Y., succeeding DR. ROBERT M. ELLIOTT, retired.

MYN M. HOFFMAN has been appointed superintendent of the U. S. Navy Nurse Corps, having served as assistant superintendent since last March. Miss Hoffman entered the navy service in 1917. She will make her headquarters in Washington, D. C.

DR. M. F. HAYGOOD, superintendent, State Tuberculosis Sanatorium, Alto, Ga., has been granted an indefinite leave of absence to become medical supervisor for the FERA in Georgia.

LEIGHTON CALKINS has been reelected president of Muhlenberg Hospital, Plainfield, N. J., for the tenth consecutive year.

M. A. BARTLEY has been named superintendent of Beverly Hospital, Beverly, Mass.

SISTER ALBERTA is now superintendent of St. Mary's Hospital, Milwaukee.

HOW 107 HOSPITAL DIRECTORS CUT THEIR OVERHEAD

—Underfoot

★ Nothing so clearly and instantly creates the proper first impression of a hospital as attractive rugs and carpets in public rooms and corridors, with cheery throw rugs in private rooms. ★ ★ Thousands of treading feet sense the luxury of fine carpeting. People feel that care and attention to such a factor implies a similar care and attention to the main functions of a hospital. ★ ★ Thus more and more Hospital Directors are recognizing that floor coverings are a necessary expense, but among them are at least 107 who have learned that floor coverings are not necessarily an expensive necessity. ★ ★ For, in Mohawk Rugs and Carpets, they find quality, service and beauty at *the right price.* Fine rugs, fine carpets, a thoroughly experienced advisory service, at no extra cost, and a willingness to cooperate are all Mohawk attributes. ★ ★ Inspect your floor coverings or those floors that should have them. Are your floors giving the impression of your hospital that you want to give? Cover those bare spots that a rug would make attractive. Replace carpets at the first sign of wear. And in solving your floor covering problems take full advantage of Mohawk quality, service and price.

★

MOHAWK CARPET MILLS

GENERAL SALES OFFICE: 295 FIFTH AVENUE, N. Y.

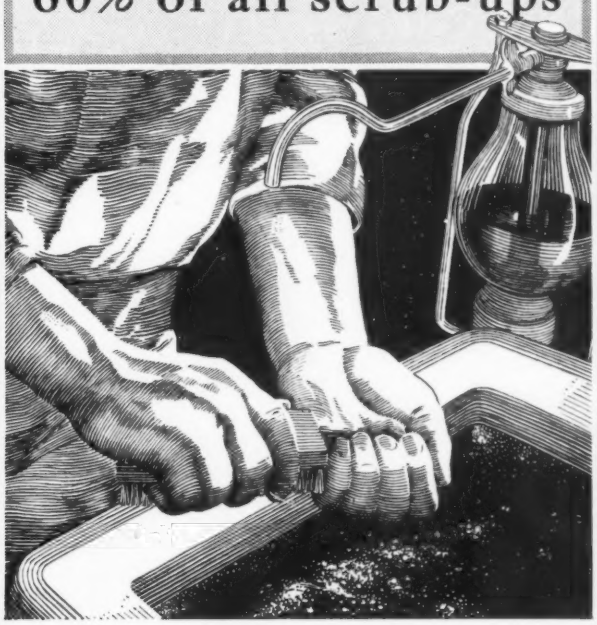
REGIONAL SALES OFFICES

Atlanta Boston Chicago Dallas Denver Des Moines Detroit
High Point Los Angeles Philadelphia San Francisco Seattle St. Louis

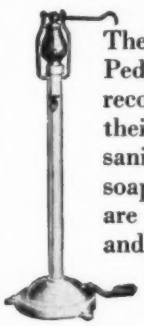
1935, Mohawk Carpet Mills, Inc.

Germa Medica

. . used in more than 60% of all scrub-ups

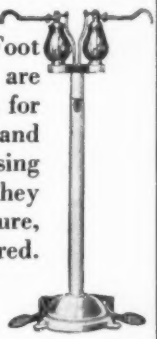


More than 2000 hospitals use Germa-Medica Concentrated Liquid Surgical Soap. For Germa-Medica's rich lather works easily into the pores, flushing out dirt in a minimum of time, and leaving the skin surgically clean. Yet its purest ingredients, properly blended, never irritate—never chafe the hands. Highly concentrated—containing 43% of soap solids, Germa-Medica may be reduced with 3 or 4 parts water, making it very economical in actual use.



The Levernier Portable Foot Pedal Soap Dispensers* are recognized by the hospitals for their economical, positive and sanitary method of dispensing soap at the scrub-up sink. They are operated by foot pressure, and can be moved where desired.

**Furnished without charge to users of Germa-Medica*



HOSPITAL DEPARTMENT

The HUNTINGTON LABORATORIES Inc.

HUNTINGTON INDIANA

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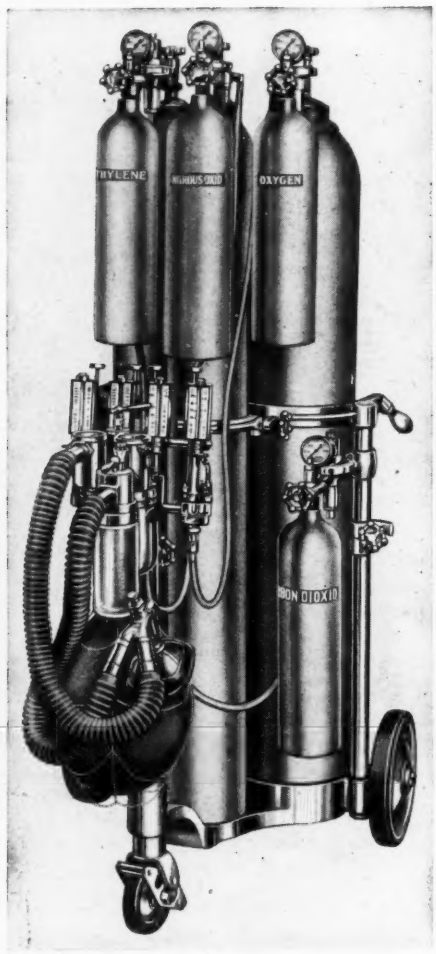
KINET-O-METER



The ULTRA-ECONOMICAL
Absorber Equipped Gas Apparatus

Revolutionizes and simplifies gas anesthesia administration.

Produces better anesthesia at greatly reduced cost. One tank of gas now goes as far as four or five tanks did using old methods.

The patient's condition is better during operation and post-operatively.

Operation is easy. A simple dry-float kinetic type flowmeter controls, measures, registers and delivers each gas independently and accurately for all types of cases.

Valuable exclusive features aid the anesthetist.

FREE ILLUSTRATED CATALOGUE SENT ON REQUEST

The HEIDBRINK CO.
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BOOKS ON REVIEW

THE PAPERS OF CHARLES V. CHAPIN, M.D. *Edited by Clarence L. Scamman, M.D. New York City: The Commonwealth Fund,* 1934.

This book consists of sixteen addresses and papers by Dr. Charles V. Chapin, carefully selected for publication by Dr. Clarence L. Scamman of the Commonwealth Fund. These sixteen papers and addresses are like milestones in the progress of disease prevention. For health officers, city, county, state and federal, for those concerned with the construction and management of hospitals, especially hospitals for communicable diseases, for both physicians and nurses whose responsibilities have to do with the transfer of infection, this small book of 228 pages should constitute an essential part of their library.

Charles V. Chapin graduated in medicine in 1879, two years after Pasteur's discovery of the anthrax bacillus as the cause of anthrax, a discovery which perhaps more than any other might be said to mark the beginning of modern medicine. Shortly after graduation he became connected with the department of health of his native city, Providence, R. I., and in 1884 he became health officer of Providence and remained for forty-eight years, until 1932, in charge of his city's health work.

These selected papers and addresses are grouped into three parts. Part I is important contributions to public health administration; Part II is more important papers bearing upon methods of disease control; Part III consists of studies in epidemiology, the incidence of disease, its manner of propagation and the methods of successful attack against it.—W. S. RANKIN, M.D.

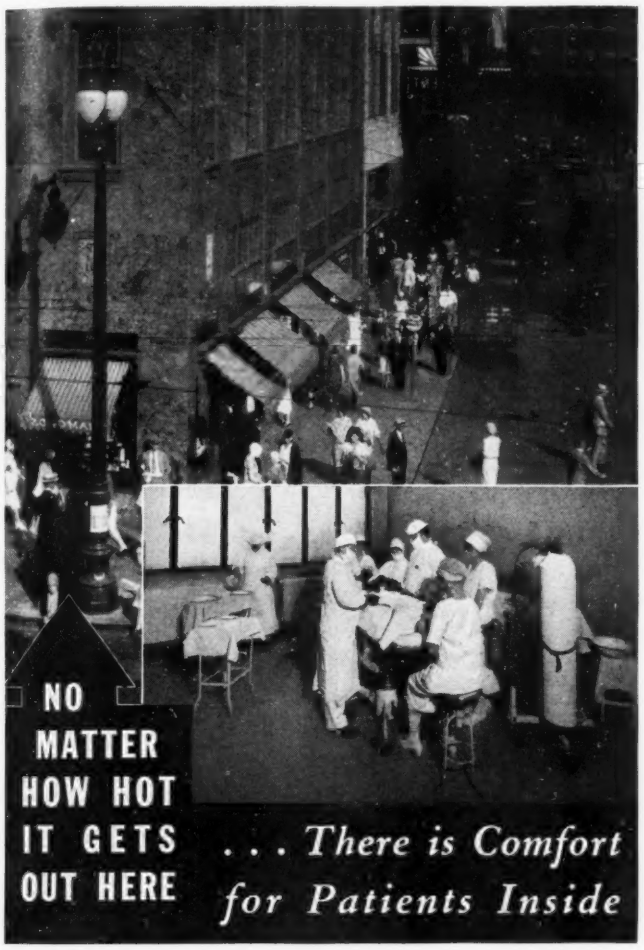
PRACTICAL EVERYDAY CHEMISTRY. *By H. Bennett, F.A.I.C. New York City: Chemical Publicity Company.*

The book "Practical Everyday Chemistry" opens to the layman a wide and interesting field of which he has no doubt been aware but which has seemed for the most part mysterious and far removed. The information given should make the average layman conscious of the hocus-pocus which some industries have practiced for many years. Considering its size the book presents an amazing store of information which is worth while even if the purchaser has no yearning to putter about among the smells of the chemical laboratory.

Certain chapters that will interest the average reader are done well and the compounds explained can certainly be used to good advantage by the layman. The chapter on photography is outstanding in this sense. From the information given, the necessary solutions for developing, electrotyping and etching can be made up, and, given a degree of patience, the layman can use them efficiently. The chapters on coatings, materials of construction, polishes and abrasives, soaps and cleaners, textiles and fibers are interesting and contain many formulas useful to the hospital superintendent. The text stresses the fact that a degree of patience and experimentation must be practiced.

The book no doubt does not intend to be misleading, but it might be assumed by the layman that the products that he could make would be equal in quality to those produced by commercial firms. In most cases this is not true because in commercial practice many special techniques are employed necessitating special equipment.

The book is interesting, instructive and of considerable value to the busy hospital executive.—GERARD R. HODGES.



You may already know

Hospital executives and members of the medical profession have been among the first to recognize the advantages pertaining to air conditioning as applied to hospitals, particularly in work with respiratory diseases, incubation rooms and maternity wards. It has been Kelvinator's privilege to work hand in hand with many of them in the solution of similar important problems.

In over 20 years of specialization in controlling temperatures, Kelvinator has acquired an unusual knowledge and has developed a staff of engineers and a line of equipment which make Kelvinator outstanding in the field to-day. Kelvinator air conditioning engineers will appreciate the opportunity to cooperate with you in solving special problems involving the application of air conditioning. Consult Kelvinator. . . . KELVINATOR CORPORATION, *14250 Plymouth Road, Detroit, Mich. Factories also in London, Ont., and London, England.*

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Specialists in Controlled Temperatures Since 1914
Air Conditioning
Household Refrigeration
Automatic Heating
Water Cooling
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Milk Cooling
Commercial Refrigeration
for every need of merchants, manufacturers and institutions

(1015)

KELVINATOR
Air Conditioning

Are They Getting
MODERN LIGHTING
in The Operating Rooms?

Supplement Inadequate Illumination With This Castle Spotlight

When circumstances prohibit the replacement of inadequate illumination with a large modern operating unit (like Castle Light No. 10*), you can at least supplement present lighting with this Castle Spotlight. Castle Light No. 40 is designed to project a cool beam of shadow-reducing light having a maximum intensity in excess of 4000 foot candles. It gives abundant illumination for *accurate, effortless* vision.

The No. 40 is sturdily constructed for heavy-duty service. Easy to focus. Head of the light is controlled from outside the sterile field by a special device. Reflector is silver-plated to prevent tarnishing.

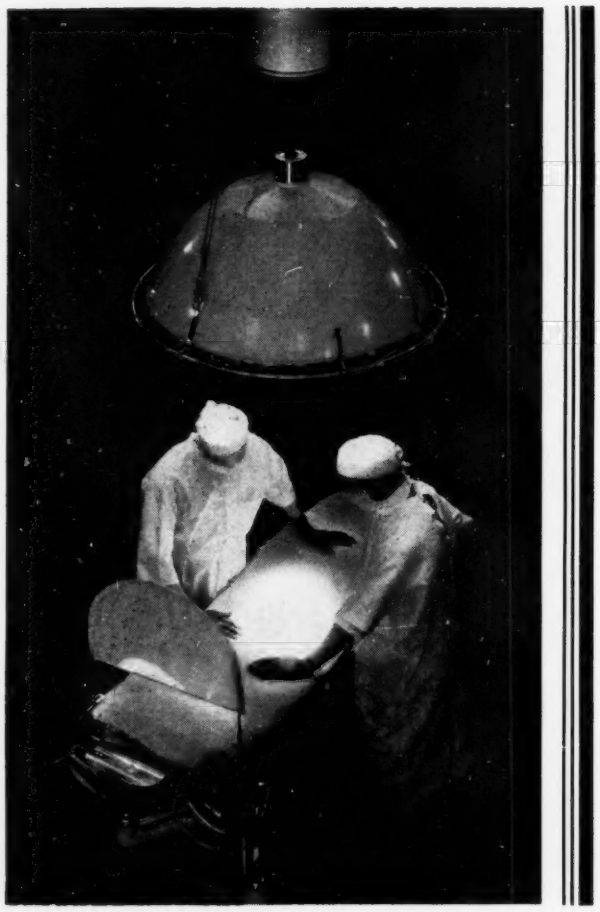
This Spotlight is finished in non-chipping white enamel and nickel plate. Plugs into any outlet, A.C. or D.C. *Write for new brochure on surgical illumination. Wilmot Castle Company, 1271 University Ave., Rochester, N. Y.

CASTLE STERILIZERS

In addition to Castle Lights, the Wilmot Castle Company has been the recognized leader in sterilization equipment manufacture for over 50 years. Write for "Hospital Sterilizer" Catalog.

CASTLE LIGHTS

APPROVED BY AMERICAN COLLEGE OF SURGEONS



MORE LIGHT—LESS HEAT!

The RIES-LEWIS
OPERATING LIGHT

Most surgeons who work under the Ries-Lewis Operating Light take for granted its precise, shadowless illumination, because the dependability of the Ries-Lewis Light is characteristic of modern Wocher equipment. But its cool operation when compared with other lights, has so added to the comfort of the operator, especially in the sweltering heat of summer, that it has won the enthusiastic approval of surgeons throughout the country.

The Ries-Lewis Light uses a single low wattage bulb and by actual comparison has proven that it produces MORE light with LESS heat. That is why the most modern equipped hospitals use Ries-Lewis Lights, insuring for operators the best possible illumination and utmost comfort.

Write for complete details.

WOCHER'S
THE MAX WOCHER & SON CO.

Instruments and Surgical Equipment

29-31 West Sixth St. Cincinnati, Ohio

NEWS FROM MANUFACTURERS

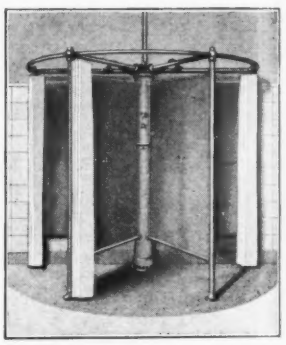
Dr. Klein Now With Roche

Announcement has been made by Hoffmann-La Roche, Inc., Nutley, N. J., that effective January 1, Dr. Louis Klein assumed direction of all Roche medical activities. Doctor Klein joins the Roche organization after a long term of noteworthy service with another leading pharmaceutical house where he held a similar position.

"Three-in-a-Group" Shower

A new semicircular group shower has been introduced by the Bradley Washfountain Co., Milwaukee.

The new shower accommodates three users at one time, each in a separate, roomy compartment, and yet requires only three plumbing connections — two supplies and one drain — thus affording marked installation economies. In addition, the fixture reduces water consumption and, by means of a specially designed Bradley mixing chamber, practically eliminates the scalding hazard, according to the manufacturer's statement.



The framework of the shower is constructed of seamless steel tubing, partitions are of heavy patent leveled sheet, and the entire unit is finished in artillery-gray baked enamel. It is equipped with white duck curtains and may be had with supply connections from above or below.

Concealed Radiators

The installation of radiation and piping thereto in institutional buildings has always been a problem to the architect and engineer because of the hazards involved to the inmates where ordinary radiation is used. The burden of designing individual radiators for each project has usually rested with the architect and engineer. Because of the many and varied designs evolved, costs of these installations usually increased above normal.

An institutional type radiator designed especially to fill this need has been announced by Warren Webster and Company, Camden, N. J. This new institutional radiator is an adaptation of the general features of standard Webster System Radiation into a distinctive type of radiator which, according to the manufacturer, prevents mentally incompetent persons from tampering with it and injuring themselves.

The complete radiator includes enclosure with grilles and heating element. The heating element is provided with an orificed, built-in lock-shield steam supply valve, thermostatic return trap and union connections for connecting the heating element to the system piping. The grilles are attached by means of tamperproof screws. An opening is provided in the lower grille for insertion of a loose key to operate the steam supply valve. The heating element, including valve and trap, may be inserted or removed through enclosure inlet.

"125 HELPLESS PATIENTS, INCLUDING 14 CHILDREN"

Photo International Newsreel

All too often newspaper headlines tell tragic tales of panic and of death, when fire strikes a hospital or institution. Where the lives of the helpless are at stake, there is a moral obligation to provide the most efficient fire protection that science affords. And since the underlying reason behind most serious fires is *belated discovery,* no protection can be regarded as adequate unless it includes some means to detect and report fire *instantly* and *automatically*.

The fastest and most efficient fire detecting and reporting system is the A. D. T. AERO Automatic Fire Alarm. No matter when or in what part of the building a fire may start, AERO will detect it immediately, and will automatically notify hospital attendants and the fire department . . . quietly, quickly and accurately. Trained forces are summoned in those first few minutes when the fire can be put out without alarming patients.

AERO has a brilliant record of protection in hospitals and institutions, large and small, throughout the country. AERO is installed and maintained only by A. D. T., a nation-wide organization for the protection of life and property. No capital investment is required. Descriptive literature will gladly be sent on request to the American District Telegraph Co., 155 Sixth Avenue, New York.

AERO—"feels the first breath of fire"

Controlled Companies of AMERICAN DISTRICT TELEGRAPH COMPANY
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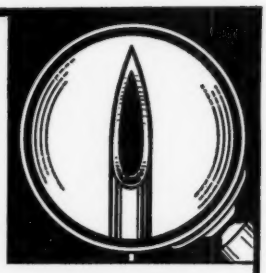
A.D.T. SYSTEM — A NATION-WIDE PROTECTION SERVICE AGAINST FIRE, BURGLARY AND HOLDUP — A·D·T

The
NEEDLE
with a
permanent
SHARP EDGE



Nothing takes the place of steel. VIM Needles are made from genuine Firth Brearley Stainless Steel—they remain sharp indefinitely. They do not have to be wired or dried after cleansing. VIM Needles outlast ordinary Needles as much as 5 times. Ask for them by name—VIM, the needle with the permanent sharp edge and the Square Hub.

VIM STAINLESS STEEL NEEDLES

CONSTANT QUALITY..
will save materials and time

WHEN your x-ray laboratory makes radiographs, when cardiograms are required in diagnosing heart disorders, when photographs are wanted to illustrate case records, pay especial attention to the recording medium and equipment. For the value of the results is influenced by the efficiency of the material.

Eastman products for radiography, cardiography, and photography will help maintain efficient routine. Technics can be standardized, time saved, materials conserved.

EASTMAN KODAK CO.
Medical Division Rochester, N. Y.
NRA CODE

New Design for Hot Water Bottles

A hot water bottle that departs from traditional forms of construction has been brought out by the Davol Rubber Company, Providence, R. I. In outline, its shape is conventional, but a flattened section extending upward from the center of the base gives the bottle a concave shape. This concavity is said to increase the effectiveness of the bottle by enlarging the area of direct heat contact.

When filled it weighs considerably less than the conventional bottle of similar size. A further practical advantage claimed for the new bottle is its pronounced tendency to cling snugly to the part of the body to which it is applied. Another feature is the roughened inside surfaces, which, according to the manufacturer, prevent the bottle from sticking together.

Reducing Cleaning Costs

A new finish for floors of wood, terrazzo, cement, cork and linoleum, designed to reduce maintenance costs by eliminating the necessity of scrubbing, has been announced by American Floor Surfacing Machine Co., Toledo, Ohio.

Pentra-Seal, according to the manufacturers, is easily applied and drys over night. It seals the surface and prevents dirt from getting into the floor. Dust and dirt can be removed from the floor with a brush or broom and an occasional buffing with a polishing brush. The product comes in a variety of colors. It is waterproof and will resist ink and stains, according to the manufacturer.

New Trade Catalogues and Pamphlets

Johnson Service Company—Two booklets, one of twenty-four pages and the other of sixty-four pages, have been published by Johnson Service Company, Milwaukee. The smaller of the two booklets gives many interesting facts concerning the Johnson Dual System of Temperature Regulation. The larger booklet is devoted to a discussion of Johnson Temperature and Humidity Control.

Continental Coffee Co.—Rules for making good coffee are given on an 8½ by 10½-inch card that is being distributed by the Continental Coffee Co., 371 West Ontario Street, Chicago. The card is for hanging in the kitchen where it can be seen readily by the personnel in charge of coffee making.

The Bay Company—A booklet from The Bay Company, Bridgeport, Conn., a division of Parke, Davis & Co., introduces OrthAletic Plaster, which is especially designed for use in two fields—orthopedic and athletic strapping. Various examples of strapping are illustrated.

The Howell Co.—Two interesting catalogues have been issued by The Howell Co., Geneva, Ill., describing the company's line of Modern Chromsteel Furniture and also its newer product, Modern Summer Furniture.

Ralston Purina Co.—Research laboratory reports on the Ralston wheat cereal and on a cereal for babies are issued by the Ralston Purina Co., St. Louis. The reports explain when and how these cereals may be prescribed to the best advantage for infant and adult patients.

The Huntington Laboratories, Inc.—Three folders from The Huntington Laboratories, Inc., Huntington, Ind., portray San-Pheno, a disinfectant, Germa-Medica, a liquid surgical soap, the Levernier portable foot pedal soap dispenser, and an antiseptic, self-sterilizing oil for babies. Directions for using the baby oil with Baby-San are given in the "Huntington Laboratories' Infant Bathing Routine."